

# Study of Local Spatial Planning Process and Health

Final Report

August 2010



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## Executive Summary

This is the report on a study into the way that health issues are currently integrated into spatial planning in this country. This qualitative research was commissioned by NICE to inform guidance on this subject which is planned for publication in 2011. The research aimed to assess how well health issues were being considered within the decision-making processes in local spatial planning as a basis for improving health in the longer term.

The study was undertaken in two broad phases between April and July 2010. The first phase of work consisted of a review of the policy framework, a review of a sample of spatial planning documents representing current practice, and interviews with stakeholders. Findings from these activities informed the research questions to be addressed in the second phase of work and the selection of areas for the case studies.

Seven case studies were undertaken, in Bexley, Hinckley & Bosworth, Manchester, Somerset, South Cambridgeshire, Stoke on Trent, and Tower Hamlets. Towards the end of these case studies, two workshops were held with invited practitioners in Birmingham and London to test and explore the emerging findings.

Reporting on this study and its results is set out in seven chapters. Below is a brief description of the purpose of each chapter, together with the respective evidence statements.

It is important to recognise that the study was conducted during a period of substantial political and policy change. The new Government is currently engaged in the formulation of new policies in the area of spatial planning. Consequently, it is likely that some issues highlighted here will be subject to change.

### Chapter 1: Introduction

The introduction sets out the detailed brief for the study and provides an overview of the methodology used. Details of the methodology can be found in Appendices A-E. Appendix F provides the note of workshops held to explore the initial findings of the study. At these workshops, participants offered suggestions for areas which they considered would be of value for coverage in the NICE guidance; and these recommendations are reported in Chapter 1.

## Chapter 2: The Policy Framework

This chapter reports on the extent to which national guidance to planners and health professionals sets out expectations with regard to the integration of health into local spatial planning decisions.

### *Evidence Statement 1:*

*Official guidance to spatial planners makes them aware that positive health outcomes should be a strategic objective to be addressed as part of the agenda for sustainable communities. Guidance does not, however, advise them of how this should be addressed; although there appears to be a general expectation that planners should be engaging with professional expertise from other areas to support their evidence and decisions.*

*The RTPI has published policy guidance on health in spatial planning, and this appears to be well known among practitioners. The comprehensive set of practical guidance published by HUDU is readily available to planners but appears to be little known outside of London.*

### *Evidence Statement 2:*

*Provision with health facilities should be an essential element of local spatial planning due to their status as part of every area's physical infrastructure. Developer contributions under s106 agreements or the proposed CIL framework provide a vehicle for resource input to health facilities, and hence a strong motivation for health bodies to engage in the planning process.*

### *Evidence Statement 3:*

*It is important for health outcomes to be recognised as a "material consideration" for them to be taken properly into account in planning decisions. Currently, national guidance does not provide this status. However, there is scope within LDFs for explicit policy reference to health outcomes to endow health outcomes with the status of being material to planning decisions.*

### *Evidence Statement 4:*

*The bulk of policy guidance on local transport plans (LTPs) is found at any time in a single document. This guidance has signalled the importance of health outcomes for several*

*years, but the expectations of direct action in this respect are now much more explicit in the latest guidance for LTP3.*

#### **Evidence Statement 5:**

*National policy guidance to health professionals does not explicitly require them to engage in spatial planning processes. However, it promotes policies which necessitate action on the determinants of health as an effective means of achieving health outcomes, which implies a role for spatial planning as a potential vehicle for effective interventions. A NHS practice guide does make a very strong case for engagement by PCTs in the spatial planning process.*

#### **Evidence Statement 6:**

*Government guidance on JSNAs requires them to cover areas of need for health and wellbeing which are potentially influenced by spatial planning decisions. PCTs are jointly responsible for JSNAs and also members of LSPs, which should address the needs identified in formulating SCSs. PCTs' involvement in delivering LAAs should require a degree of coordination with LDFs, which are the spatial manifestation of SCSs. Implicit in these arrangements is a need for the decision-making processes for JSNAs, SCSs, LAAs and LDFs to be coordinated, and hence for an engagement between health and spatial planning. This presents a particular challenge of communication and coordination in two-tier local authority structures, where the LAA relates to the county area, and spatial planning is the responsibility of boroughs and districts.*

## **Chapter 3: Document Reviews of Current Practice in Planning**

A document review was undertaken of all regional spatial strategies (RSSs) and a sample (14) of Local Development Frameworks (LDFs). These were treated as examples of outputs from key decision-making processes in spatial planning. The reviews established how health issues had been presented in the statutory documents, and then, wherever practicable, explored how these had been produced.

#### **Evidence Statement 7:**

*The current set of RSSs provides ample evidence of health being on the agenda of spatial planning at that level. Treatment of health is, however, far from uniform, and particularly with respect to any inclusion of policies setting out expectations for health to be addressed in the subordinate LDFs. Where such policies are included, they do not provide clear guidance on how health issues are to be addressed. The recent Government*

*announcement of an intention to abolish the regional level of spatial planning has seriously reduced the relevance of these findings. However, they do indicate how health might be handled in the future if there were any higher-order strategies able to influence local spatial planning.*

#### **Evidence Statement 8:**

*HIAs undertaken on RSSs might have been considering the impact of the intended outcomes of policies, and not the impact of the policies themselves. This may have undermined decisions on policies which relied on the HIAs.*

#### **Evidence Statement 9:**

*The sample of LDFs demonstrates that the pursuit of health outcomes has been accepted as a legitimate issue to be addressed in local spatial planning. Health features both explicitly and implicitly in objectives and policies. Promoting healthier communities was a theme found in both prosperous and deprived areas, and better access to healthcare provision was a common objective or policy. While most LDFs acknowledged that policies and other factors impact on health, the implied causal links between policies and outcomes were generally neither strong nor explicit. The respective PCTs appeared to have been engaged to varying degrees in core strategy preparation but relating to the practicalities of providing facilities, rather than to policies promoting healthier lifestyles or addressing health inequalities.*

#### **Evidence Statement 10:**

*Among the initiatives aimed at better incorporating health issues into the activities of local authorities, relatively few referred explicitly to spatial planning. The WHO Healthy Cities programme was one initiative found to have spatial planning at its core, as a means of addressing determinants of health.*

## **Chapter 4: Planners' Approach to Health**

The seven case studies were used to explore with practitioners how they approach health issues in their spatial planning work. This covered not only forward planning work on LDF documents, but also development management, transport planning, and regeneration. The aim was to establish the reality of practice on the ground.

**Evidence Statement 11:**

*A widespread awareness was found among planners that they should be pursuing health outcomes in their activities. This appears to derive from a degree of importance and prioritisation being attributed to health within the local authorities for which they work, typically manifest in the local sustainable community strategy. Further reinforcement appears to come from a relatively vague notion that national planning guidance presents health as part of sustainability.*

**Evidence Statement 12:**

*Spatial planners' policies to address health outcomes appear to have but a weak foundation in specific knowledge and understanding of how they can influence the determinants of health. Many spatial planners would welcome better information and guidance on how to address health outcomes, and particularly if this were embodied within formal national policy guidance. This was less the case for transport planners, who appeared much more comfortable and confident that guidance provided a sound basis for taking health fully into account in their decisions. There was little evidence of planners being either aware of guidance from NICE and the DH, nor any belief that this would be of relevance to them.*

**Evidence Statement 13:**

*Despite the requirement for LDFs to comply with RSS policies, local priorities and not RSS expectations appear to be the main driver in directing LDF policies towards health outcomes.*

**Evidence Statement 14:**

*Local sustainable community strategies (SCSs) normally exert a strong influence on the broad objectives and priorities to which local spatial plans are directed, and this has been one of the key reasons for health outcomes being picked up in LDFs. Nonetheless, the impact of SCS prioritisation for health appears to be limited when little guidance is provided regarding what role and outcomes are actually expected from spatial planning. There appears sometimes to be an even stronger disconnection between the SCS of a county and the spatial planning being undertaken by the lower-tier planning authorities. This is an issue which is only partially addressed through the latter's own SCSs, particularly if the main focus of the respective PCT's engagement in local strategic partnerships (LSPs) is at county level.*

## Chapter 5: Health Professionals' Approach to Spatial Planning

Analogous to Chapter 4, this chapter reports on an examination of how health professionals engage in spatial planning at the local level. Although starting with the work of PCTs, the case studies also covered public health staff working in local authority or other structures outside of the main PCTs.

### *Evidence Statement 15:*

*PCTs do not normally view engagement in spatial planning as core business. In organising their staffing structures around core business, some PCTs were found to have inadvertently created situations in which no member of staff recognised a responsibility for liaison with spatial planners. This was particularly marked where two-tier local government structures led to the PCT's focus lying in cooperation with the county council as social care authority, while spatial planning is a district function.*

### *Evidence Statement 16:*

*An extremely varied knowledge of spatial planning was found among health professionals, even among individuals designated as responsible for liaison with the district authorities in their spatial planning function. The better working relationships between PCT and planning authority tended to be found where responsibility for this in the PCT involved someone with a good understanding of spatial planning.*

### *Evidence Statement 17:*

*In the absence of national guidance requiring it, PCTs appear unlikely to engage actively in spatial planning, their default position being to focus their structure and resources on the core business of which spatial planning is not a part. On the other hand, when a reason for corporate self-interest pointed in this direction, PCTs were found to have been well able to organise themselves to facilitate engagement in spatial planning. Motivation for engagement is, however, not sufficient; for effective engagement by PCTs in spatial planning also appears to require local leadership and staff with knowledge of spatial planning and/or with planning liaison in their job description.*

## Chapter 6: Interaction between Health Professionals and Planners

Having looked at planners and health professionals separately, this chapter reports on the examination of how the two are interacting in practice. It explores the operation of formal arrangements, means of communication, cultural differences, and practical issues.



**Evidence Statement 18:**

*The case studies revealed a very wide range of different arrangements for collaboration between PCTs and local authorities. Although some were specifically designed to facilitate health input into spatial planning, it was far more common that this was but one part of more broadly-based arrangements. No strong correlation was found between the type of arrangement adopted and success in integrating health into planning, and factors such as political priorities and the knowledge of individual practitioners' appear to be of at least equal importance. In particular cases the creation of a public health capability within a local authority's structure provides a ready health input into spatial planning, potentially avoiding reliance on resources being made available from within the PCT's structure.*

**Evidence Statement 19:**

*Where health professionals are engaging in spatial planning, the representatives of the two professions appear to be learning about one another's cultures, and hence reducing the scope for misunderstanding and friction between one another. Nonetheless, there is still some way to go: some differences in language, culture and approach remain, and hence issues may yet arise.*

**Evidence Statement 20:**

*Although several practitioners made reference to there being problems of cooperation between health and planning relating to their respective time horizons, little evidence was found to support this being a real issue.*

## **Chapter 7: Matters for Consideration if Spatial Planning is to aim at Health Outcomes**

This final chapter attempts to highlight some of the main issues which need to be addressed if health outcomes are to be fully taken on board in spatial planning decisions. It looks at the main obstacles and at what can be identified as key factors for success. Some examples are also offered of local practice that might be worth further exploration.

**Evidence Statement 21:**

*Unless there is real political prioritisation of health outcomes among members, a council's approach to health in spatial planning is likely to be little more than tokenism. This is irrespective of apparent prioritisation in a SCS. Conversely, if there is real political backing for the pursuit of health outcomes, it is possible to initiate a comprehensive corporate*

*approach to the pursuit of health that should automatically incorporate spatial planning as an intrinsic element.*

#### **Evidence Statement 22:**

*Planners are manifestly conscious of the expectation that their policies are based on sound evidence, particularly the need for them to stand up to challenge at a public enquiry or examination. Nonetheless, they appear to be quite content to pursue policies promoting health outcomes despite the lack of specific evidence that the policies in question will themselves lead to better health. They acknowledge that policies which lead to greater provision with open space, cycling routes and safe pedestrian routes will not automatically produce healthier behaviour among the target population. At the same time, they clearly recognise the evidence that more use of these facilities should improve health, and therefore trust that others' actions complementary to their policies can help the population to make healthy choices in their behaviour.*

#### **Evidence Statement 23:**

*JSNAs are generally not satisfying the needs of planners for data inputs to their processes, and they are not providing a solid foundation for joint working with PCTs. While some planners are disappointed by their lack of involvement in Joint Strategic Needs Assessments (JSNAs), others had never heard of them. Evidence was offered in the studies suggesting that health outcomes had hardly ever been used as grounds for refusing planning permission. Examples were also provided of the difficulty encountered when seeking to use developer contributions for health facilities. These problems reflected the difficulties encountered in establishing robust evidence linking health impact to a particular development, and also the unanswered question of when health constitutes a material consideration in planning decisions.*

#### **Evidence Statement 24:**

*Planners generally believe that health outcomes have hardly ever been used as grounds for refusing planning permission, and that to seek to do so would probably result in failure. They also report problems encountered when seeking to use developer contributions for health facilities. These limitations on action reflect partly the difficulty of establishing robust evidence that links specific health outcomes to any particular development. They also follow from serious doubts whether health would be considered at appeal to be a material consideration in a planning decision. Related to this, there appears to be a common belief that, if national planning guidance were formally to establish health as a material consideration, this would both remove these doubts and also enable evidence of health impact to be handled on the basis of reasonable probability rather than absolute proof.*

**Evidence Statement 25:**

*Although health inequalities are widely recognised as being strongly correlated with the social and economic inequalities manifest in regeneration areas, there is little evidence of health being given priority in regeneration. Health provision is not viewed as a determining factor in making regeneration areas more attractive; and there is always a fear that the people with health problems are likely to be displaced to other areas.*

**Evidence Statement 26**

*The use of HIAs is not universal, reflecting varying perceptions of whether the cost and time involved can be justified by the benefit. An example was found of “mini-HIAs” being developed - a simpler process requiring far less resource - which might offer a more beneficial approach.*

**Evidence Statement 27:**

*A growing interest was found in the local development of supplementary planning guidance within a LDF to entrench health issues more firmly into development management. This is seen as presenting an opportunity to provide much more detailed guidance than in a core strategy. Significantly, it is also recognised as presenting an opportunity to establish health as a material consideration in planning decisions, even without national guidance.*

**Evidence Statement 28:**

*There appears to be very little meaningful monitoring of spatial planning policies which are aimed at health outcomes: the implementation of policies is not always being monitored, nor the direct effect of the policies in terms of their impact on health in accordance with what was intended. Generally, only broad health indicators are being monitored - primarily those used for LAAs - and planners appear to be well aware that these cannot be linked directly to the effects of their policies.*

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## STUDY BRIEF

### ***Aim and Objectives***

The overall aim of the study is to investigate effective ways of integrating health considerations within the spatial planning process to contribute to improvements in health and reducing health inequalities, based on the views and experiences of those involved in this process.

The study will address the following principal questions:

- How and when are health objectives and issues considered in the spatial planning decision-making process? What factors influence how these health objectives and issues are considered? How does the regional/national level (including macro-economic factors) influence how health issues are considered?
- What approaches and techniques are used to assess ways of promoting health and reducing health inequalities when making spatial planning decisions, and what is their impact on decisions and plans and developments? What factors influence whether and how these plans are implemented?
- What arrangements exist for collaboration between planners and health professionals to support integration of health within spatial planning process? What resources (including skills, expertise, information, evidence, finance) are available to support this process?
- What examples demonstrate promising/effective ways of integrating health in the spatial planning process? What factors influenced success? What examples demonstrate difficulties in integrating health in the spatial planning process? How could difficulties/barriers be overcome?
- What principles and standards are needed to ensure both the quality of the health assessment process and its impact on spatial planning decisions?

### ***Approach and Methods***

The study approach should comprise:

- A small number of local in-depth case studies of local authority 'spatial planning areas' (in England) that investigate the above questions. Spatial planning areas would relate to areas covered by Local Strategic Partnerships and Sustainable Community Strategies / Local Area Agreements. The case studies should include areas of disadvantage - e.g. designated Spearhead/urban regeneration areas - but other areas of known good practice could be included. At least one case study should examine the role of the regional level in-depth, and multi-local-authority arrangements might also be selected to explore pan local authority plans.
- Participation of key stakeholders based on interviewing and workshops. Participants should include representatives of local authority planning and related departments, including transport, environmental health, economic development, PCTs (public health, service delivery), developers, Local Strategic Partnership forums, local politicians, regional government office planning, community/neighbourhood area forums.
- Documentary analysis: including regional spatial plans, Local Development Framework documents, Sustainable Community Strategies, Local Area Agreements, selected plans and projects relating to health-related developments (e.g. transport, economic development/regeneration, and housing).

# 1 Introduction

- 1.1 The National Institute for Health and Clinical Excellence (NICE) is developing guidance on Spatial Planning and Health for local planning authorities and primary care trusts (PCTs). Scheduled for publication in December 2011, the guidance will provide recommendations to help ensure that the opportunities for promoting health and wellbeing are fully considered within the local spatial planning process. The guidance will be based on a review of the best available evidence found in current practice and in the experience and opinions of those involved.
- 1.2 A team formed by Strategic Solutions and Three Dragons undertook a study on current practice in this area which had been commissioned by NICE to inform their guidance. The focus of the study has been on decision-making processes within the spatial planning system. It is therefore about practice, not theory. Theories and formal policies and structures may well influence practice; but the study was intended to identify the much wider set of factors that influence decisions on the ground. By reporting on findings in this area, it is hoped that the future guidance informed by this qualitative research can be made much more effective.

## Study Brief

- 1.3 The original brief provided by NICE for the study is set out in the box on the facing page. This was used as the basis for designing the detailed plan for the research work, which commenced in late March 2010 and was completed in the following July.
- 1.4 It is worth noting at this point that the general election of May 2010 brought a change of Government, a degree of uncertainty, and actual policy changes during the study. Since the study was essentially looking at practice in the immediately preceding years, these developments did not affect the substance of the study's findings. Nonetheless, given that the use of this was to be as evidence for future guidance, occasional reference is made in the report to the changed circumstances and how these might influence the interpretation and/or relevance of the research findings.



## Definitions

- 1.5 In the context of the study, an initial definition of spatial planning could be taken from the Government's guidance in Planning Policy Statement (PPS)12<sup>1</sup>:

*“Spatial planning is a process of place shaping and delivery. It aims to:*

- *produce a vision for the future of places that responds to the local challenges and opportunities, and is based on evidence, a sense of local distinctiveness and community derived objectives, within the overall framework of national policy and regional strategies;*
- *translate this vision into a set of priorities, programmes, policies, and land allocations together with the public sector resources to deliver them;*
- *create a framework for private investment and regeneration that promotes economic, environmental and social well being for the area;*
- *coordinate and deliver the public sector components of this vision with other agencies and processes [e.g. LAAs<sup>2</sup>];*
- *create a positive framework for action on climate change; and*
- *contribute to the achievement of sustainable development.” (§2.1)*

This is essentially a definition designed to match the intentions enshrined in the legislation determining the purpose and content of spatial plans and strategies. It can be assumed that this strongly influences the view of planning bodies and local authority planning departments.

- 1.6 Following the brief from NICE, however, the study took a slightly broader definition of spatial planning, reflecting the generic meaning of the term “spatial”. Thus, it embraced other formal planning processes linked to locational selection and initiatives for area-based actions at particular locations. On this basis, the key local activities that emerged for inclusion were strategic transport planning, area-based regeneration activity, and housing strategies.

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<sup>1</sup> See §2.14

<sup>2</sup> LAA = Local Area Agreement (see §2.66)

## The Research Process

1.7 The study was undertaken in two broad phases, as follows.

### *Phase One: Preparation for the Case Studies*

1.8 Phase One served the twin purposes of (a) identifying possible candidates for the case studies in Phase Two; and (b) generating a set of appropriate research questions to provide the kind of evidence required by NICE for formulating proposals for its guidance. There were three strands in this first phase:

- a document review of the policy framework for the activities being covered by the research,
- a document review of current practice in spatial planning, and
- interviews with stakeholders in the area of study at national and regional levels, in health, spatial planning and related fields.

1.9 Phase One activities ran broadly from late March to mid-May 2010. At the end of the process, the findings were reported to NICE, together with recommendations regarding the research questions and selection of areas for the case studies.

1.10 Questions to be answered through the document reviews are set out in Appendix A; and the selection of a sample of 14 areas for the review of local planning documents is explained in Appendix B. Their findings of these reviews are summarised here in Chapters 2 and 3. These findings informed the initial formulation of lines of questioning for the case studies, and these were then developed further using information and advice arising from the stakeholder interviews. Appendix C provides information on the organisations targeted in the interviews.

1.11 As a result, a set of proposed research questions for the case studies were discussed and refined with NICE. The agreed questions were grouped under four broad research themes, and then subdivided among a larger number of related sub-themes. These are set out in Appendix D

1.12 In parallel to this, and also informed by the document reviews and the knowledge and experience of interviewees, a selection of areas was proposed as the basis for the case studies. Seven areas were agreed for the case studies to be undertaken in Phase Two. A brief explanation of their selection is provided in Appendix E.

## *Phase Two: Case Studies*

- 1.13 Preparation for the case studies began in June, and the research ran through to the end of July. In addition to the agreed set of research questions, interviewers were briefed to ensure that different types of health outcome - health improvement, reduction of health inequalities, and provision with health facilities - should all be covered. They were also charged with exploring the following general questions with a view to the study's key objectives:
- What obstacles can be identified to the influence of health on spatial planning? How could they be overcome?
  - What critical factors for the success of health engagement in planning can be identified?
  - Is this a model of good practice? Or, if not, does it show significant potential?
- 1.14 The findings from the case studies are presented in this report in Chapters 4-7. Chapters 4 and 5, respectively, report on (i) the planners' approach to health in their decision-making, and (ii) the relationship of health professionals to spatial planning. The interaction between the two professional groups is then explored in Chapter 6. Finally, Chapter 7 considers some of the factors that need to be given attention if spatial planning is to take full account of health outcomes in decision-making processes. At appropriate points in the text, summary statements of evidence are provided.
- 1.15 Two workshops were held in the final stages of Phase Two, offering an opportunity to test the findings emerging from the case studies with practitioners from other areas. Held in London and Birmingham, invites to the workshops were sent to practitioners known to be interested in the subject of the studies. Particular sources used for this purpose were the register held by NICE of interest expressed in the project, and the membership of the RTPI's Healthy Communities Network.
- 1.16 The workshops were intended to involve a good mix of representatives from PCTs, planning authorities, and other relevant bodies. In total, they attracted 36 participants (with 11 who had accepted not being able to attend on the day). Of these, 8 were from PCTs, 11 were practicing planners, and the remainder represented a wide mix of other bodies with a local, regional or national focus. Although participants from London and the West Midlands perhaps inevitably were in the majority, attendance did have a much wider geographical spread, including Scotland.

1.17 A note of the outputs from the workshops is provided in Appendix F. Here, it is appropriate to list the recommendations made by participants at the workshops regarding areas which NICE should consider as a focus for coverage in future guidance:

- Demonstrate the need for legislation or official guidance requiring health professionals and planners to engage in the other's decision-making. This could include, for example, a planning policy statement making health a material consideration in planning.
- Provide tools that encourage and support planners in thinking about health, e.g. a health check list to use in preparing policy, or a health section in planning applications.
- Encourage planners and health professionals to use integrating "tools" effectively and to gain the appropriate skills - e.g. training and education in each other's work areas.
- Illustrate how planners and health professionals can develop better channels for engagement, including structures and information on who to contact, using "cross-over" bodies such as LSPs, or identifying leadership roles in facilitating engagement.
- Underline the importance of ensuring the necessary resources to support engagement; and highlight the long-term economic benefits of health initiatives to help make the case for resources.
- Accept the need for dispute resolution when health and planning interests/opinions diverge (e.g. for resolving issues on particular sites) and provide guidance.
- Provide good-practice examples and case studies that set out how specific health interventions have been designed, implemented and monitored.

## References

1.18 Where reference is made to documents in the text of the report, details of the document should be available in the Bibliography in Appendix G. In Appendix H, a Glossary is provided for the abbreviations used during the report.

## 2 The Policy Framework

- 2.1 The first action in Phase One of the research was to undertake a review of the national policy framework with respect to how it influences decision-making in spatial planning and the integration of health into this. Although the focus was on official Government publications, other guidance was included where this appeared to have a national significance.
- 2.2 The primary purpose of this review was to establish a starting point for an examination of practice on the ground: essentially identifying what expectations are imposed on the performance of local actors through policy guidelines. This would then provide reference points for understanding and assessing the actual practice which would then be found in the case studies. The questions initially formulated for the review are set out in Appendix A.

### Government Guidance on Spatial Planning

- 2.3 Among the plethora of formal guidance on spatial planning in recent years there has been increasing mention of the subject of health. This has emerged as the planning system has moved from a land-use focus to the more holistic aims of sustainability, a sense of place, or similar. This can be seen in its guidance on Regional Spatial Strategies (RSSs)<sup>3</sup>, namely that *“the Government’s policy on spatial planning goes beyond traditional land use planning to bring together and integrate policies for the development and use of land with other policies and programmes which influence the nature of places and how they function. ... In line with this, RSS policies should draw out the links with related policy initiatives and programmes to deliver the desired spatial change”* (§1.6).
- 2.4 This could be viewed as providing a strong incentive to seek coordination between health and spatial planning. It has certainly brought a general reorientation of spatial planning decision-making, with explicit goals including a range of outcomes that have no direct relationship with land use. Better health and wellbeing and a reduction of health inequalities may be viewed as archetypical in this respect: they may be influenced by physical development and land-use changes; but, as outcomes, they are generally not directly created by them.
- 2.5 Such health outcomes are now widely recognised among the broad goals to which planning guidance is addressed, and it will be seen that this is echoed in the plans and

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<sup>3</sup> PPS 11 - see also §2.8

strategies being produced within this policy framework. Nonetheless, these references to health in policy guidance documents are not translated into guidance on how to address health issues. Precisely how spatial planning decisions are to contribute to improved health outcomes is omitted from the planning guidance - or, more precisely, it is implicit rather than explicit. It appears to be generally left to planners operating on the ground to determine how to address health when creating the evidence base for their strategies and plans. Chapter 4 will look at how this has been achieved.

- 2.6 An important element of planning guidance is the general expectation that planners should be engaging with professional expertise in areas such as health to gain the knowledge and insight that can feed into the evidence base and hence make planning decisions effective in achieving the desired outcomes.
- 2.7 Under current legislation in England, statutory spatial planning has been required at two levels: for each region there should be a Regional Spatial Strategy (RSS), and for each local planning authority area - i.e. for a district, borough, or unitary authority - a Local Development Framework (LDF). Both levels were included in the study; although the coalition Government elected in May 2010 has ruled that the regional level of planning is to disappear.

### *Regional Spatial Strategies (RSS)*

- 2.8 The review of the policy framework for RSSs took place before the 2010 general election, and therefore preceded the new government's announcement of the abolition of regional strategies. The findings of the review are retained here nonetheless, for two reasons: RSSs have been an essential element of the policy framework within which the spatial planning reflected in this report has been conducted; and they provide a more general perspective on the possibility of influencing local spatial planning through alternative higher-order strategies at some point in the future.
- 2.9 With the disappearance of all statutory spatial planning at regional level, compliance with the respective RSS/Regional Strategy<sup>4</sup> will no longer be a criterion for judging a LDF document. Nonetheless, this need for compliance was a feature of the system under which the LDFs examined in the study had been created. Moreover, there is value in consideration of how the need for compliance with a higher-level strategy can be, in principle, a means to integrate health into the local spatial planning process.
- 2.10 The RSS has been an intrinsic part of the statutory development plan which should control and guide development in any area. As a consequence, the policy content and direction of

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<sup>4</sup> From 1<sup>st</sup> April 2010, each RSS was to be absorbed by an all-embracing Regional Strategy.

a RSS could play an important role - at least in theory - in determining much of the content and direction of spatial planning at the local level. This applies both to local development documents (LDDs - see §2.17) and Local Transport Plans (LTPs - see §2.42). In practice, however, a RSS will only influence local spatial planning on matters which are specifically addressed as issues in its policies, in so far as LDFs have to conform with the RSS.

- 2.11 Government guidance on RSSs in *Planning Policy Statement 11: Regional Spatial Strategies* (PPS 11, 2004) makes little reference to health in particular. A requirement to consider health factors is only imposed in general terms. For example, when aiming to achieve sustainable development, a RSS should take into account *“other relevant strategies and programmes at national, regional or sub-regional level [which] include but are not limited to air quality, biodiversity, climate change, education, energy, environment, health, soil use and sustainable development”* (PPS 11, §1.2).
- 2.12 Nonetheless, PPS 11 encourages a RSS to seek a wider coordinating or integrating role beyond the more limited land-use based management of development in implementing spatial plans (see below §2.24): *“[a]lthough RSS policies have to be related to the development and use of land within the region ..., they should not be restricted to policies that can be implemented through the grant or refusal of planning permission”* (§1.6). In other words, both strategic objectives and delivery mechanisms for the RSS could be couched in terms of health outcomes that are not land use, provided that land use and development play some role at some point.
- 2.13 In this context, there is clearly scope to address health issues to whatever extent is deemed appropriate for the region in question, and PPS 11 requires substantial consultation on what a RSS should be addressing. A RSS should be produced *“on an inclusive basis of partnership working and community involvement”* (§1.1): *“education and health authorities and health trusts will ... need to be consulted to ensure that the education and health implications of the draft strategy are properly examined”* (Annex D §4). Despite these references to health, when PPS 11 lists *“Potential participants in the RSS revision process”* (Annex D §54), it indicates that local health authorities and NHS trusts should be participants with regard to *“proposals with a potential health impact”*. This appears to be a much narrower scope of involvement than the tone of other references would appear to indicate.

## Local Development Frameworks

- 2.14 In the new arrangements<sup>5</sup> for spatial planning at local level, the formal development plan consists of a suite of documents (Local Development Documents, or LDDs) which together form the Local Development Framework (LDF). To assist planning authorities in working within the new LDF arrangements, the Government produced guidance in 2004 in PPS 12, entitled *Local Development Frameworks*. In 2008, a new PPS 12 replaced this, now called *Local Spatial Planning*.
- 2.15 The current guidance makes little specific reference to health. In terms of a LDF's purpose, it states that *"in relation to land and buildings it ... co-ordinates the identification and release of land for the provision of the services such as health facilities which form a crucial part of a local authority's strategic role ..."* (§2.7). Although health is clearly to be taken into account in spatial planning at the local level, health is not mentioned in the rest of the policy guidance deriving from this.
- 2.16 The LDF should be viewed as the spatial manifestation of the broader Sustainable Community Strategy (SCS) for the area in question. This applies most obviously to the Core Strategy, the central and most basic element of the LDF. The SCS was introduced as a statutory requirement for production by each local authority through the *Sustainable Communities Act* of 2007, and is to be produced in full consultation with local communities and partners, the latter through involvement of the respective Local Strategic Partnership (LSP) - which is specifically to include the local PCT. From the spatial planning perspective, the purpose of the SCS can be taken from PPS 12 as follows:
- "The Sustainable Community Strategy sets out the strategic vision for a place and is linked into overarching regional strategies. It provides the vehicle for considering and deciding how to address difficult cross-cutting issues such as the economic future of an area, social exclusion and climate change."* (§1.2)
- 2.17 Within the LDF, there are two possible types of LDD:
- Development Plan Documents (DPDs), which are subject to independent scrutiny by the Planning Inspectorate and approval by the Minister; and
  - Supplementary Planning Documents (SPDs), which are subject only to local scrutiny.

In creating a LDF, the element of central importance among the DPDs is the Core Strategy. PPS 12 states that this should include:

*"(1) an overall vision which sets out how the area and the places within it should develop;*

<sup>5</sup> *Planning and Compulsory Purchase Act, 2004*



*(2) strategic objectives for the area focussing on the key issues to be addressed;*

*(3) a delivery strategy for achieving these objectives. This should set out how much development is intended to happen where, when, and by what means it will be delivered. Locations for strategic development should be indicated on a key diagram; and*

*(4) clear arrangements for managing and monitoring the delivery of the strategy.” (§4.1)*

- 2.18 Against this background, it is clear that a core strategy may address health issues in either or both of two ways: seeking outcomes in health and wellbeing or health inequalities; or, on a more immediate basis, through provision of health facilities as part of the infrastructure. On the subject of infrastructure, PPS 12 sets out an agenda:

*“The core strategy should be supported by evidence of what physical, social and green infrastructure is needed to enable the amount of development proposed for the area, taking account of its type and distribution. This evidence should cover who will provide the infrastructure and when it will be provided. The core strategy should draw on and in parallel influence any strategies and investment plans of the local authority and other organisations” (§4.8) - presumably which should include PCTs.*

- 2.19 In the 2004 version of PPS 12, a more specific reference had been made that a core strategy is to take account of: *“the community strategy and strategies for education, health, social inclusion, waste, biodiversity, recycling and environmental protection”* (§1.9). In a footnote to the 2008 version relating to housing, the guidance explains that *“green infrastructure is a network of multi-functional green space, both new and existing, both rural and urban, which supports the natural and ecological processes and is integral to the health and quality of life of sustainable communities”* (p.5). This is the only specific reference to health as an outcome of local spatial planning.
- 2.20 If a particular part of the area covered by a core strategy requires more detailed planning, it can be covered within the LDF by the production of another type of DPD, the Area Action Plan (AAP). This might be necessary for major urban extensions, regeneration schemes, or for areas of particular challenges or opportunities. The legislation also permits the inclusion in the LDF of DPDs that address in detail a particular theme over the whole of the area. The guidance in PPS 12, however, makes it clear that these should only be produced if it is inappropriate to cover the material in the core strategy itself. It is possible that health could be a subject treated in this way in an area where there were particular issues necessitating this.
- 2.21 Supplementary Planning Documents (SPDs) also have the function of expanding on one of the DPDs in the LDF, or of providing more detail, but without the need for external

validation, since the essential policy elements should already have been dealt with in the DPD itself. SPDs do, nonetheless, require consultation within the community.

### *Infrastructure Planning*

- 2.22 PPS 12 gives more prominence to the role of infrastructure planning than has previously been the case. The tone is set by the statements that:

*“The core strategy should be supported by evidence of what physical, social and green infrastructure is needed to enable the amount of development proposed for the area, taking account of its type and distribution. This evidence should cover who will provide the infrastructure and when it will be provided. The core strategy should draw on and in parallel influence any strategies and investment plans of the local authority and other organisations”* (§4.8) - again, this should be seen to include PCTs.

- 2.23 The guidance requires this analysis and planning of infrastructure to occur as part of the preparation of the respective core strategy; but it also acknowledges that not all relevant information from providers can be assumed at this point. In other words, it foresees continuing interaction between spatial planning and the planning of infrastructure provision, implying an ongoing dialogue between planners and health professionals. Specifically, PPS 12 refers to the need to address 4 key features of future infrastructure (§4.9):

- infrastructure needs and costs;
- phasing of development;
- funding sources; and
- responsibility for delivery.

The previous government’s initiative for coordinating public expenditure on capital and revenue across all public bodies operating in an area, entitled Total Place, can be seen as something into which this approach to infrastructure would easily fit.

### *Development Management*

- 2.24 Previously referred to as “development control”, the process of development management can be viewed as the “sharp end” of the spatial planning process. Statutorily, it is the principal tool in the implementation of the LDF.
- 2.25 At the centre of the development management process are decisions whether to approve a development proposal or not. However, equally important are conditions or agreements

- associated with the granting of permission relating to obligations imposed on the developer - e.g. governing the nature of the development and any contributions made to public goods. The process leading to the decision may also involve a long period of liaison, consultation and negotiation.
- 2.26 A fundamental element of development management decisions is the question of what factors are of “material consideration” in any application for development permission. Planning law requires that only material considerations can be permitted to influence a decision; and this therefore raises the issue of how, when, and even whether health outcomes can be applied as material considerations.
- 2.27 Although there is no specific reference to health in the most recent guidance<sup>6</sup> on managing development, there may nonetheless be other factors to take into account. Firstly, every policy in a LDF adopted by the local planning authority would be material, and one or more of these could relate to health outcomes. Secondly, current Government guidance through PPS documents or Circulars is always a material consideration, and these provide further opportunity to place health among the material considerations. (This is considered below under *Other Official Planning Guidance* in §2.32.)
- 2.28 There is also a clear requirement for all significant impacts of any development to be properly assessed, and for appropriate mitigation of negative impacts to be undertaken. For large developments, this can mean a formal Environmental Impact Assessment (EIA). Health Impact Assessments may also be required by local policy; however, in England, this is still voluntary on the part of the local planning authority. While these assessments have no formal role in decision-making and cannot determine a decision, if available they should be taken into account as material considerations.
- 2.29 Lastly, health facilities are part of the infrastructure and their provision or lack of it may be material to a planning application in the same way as sewerage capacity or road infrastructure. In 2008, PPS 12 imposed a clear requirement for LDFs in this respect: *“Infrastructure planning for the core strategy should also include the specific infrastructure requirements of any strategic sites which are allocated in it”* (§4.11). This was linked directly to the Community Infrastructure Levy (CIL) that was then planned for introduction. Local planning authorities were encouraged in the guidance to progress with their infrastructure planning so that they would be best placed to take advantage of the CIL once introduced. However, when formal guidance was issued by CLG on use of the levy in March 2010, no specific reference was made to health. There is now uncertainty regarding the future of the CIL.

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<sup>6</sup> CLG, Development Management Policy Annex

- 2.30 Even without the CIL, planning authorities have been able for many years to negotiate agreements for the provision of developer contributions under Section 106 of the *Town & Country Planning Act 1990* (as amended). The critical factor in this<sup>7</sup> is that contributions cannot normally be required unless they can be demonstrated to relate directly to the proposed development itself. For example, contributions to health facilities and/or services might be required if it can be demonstrated that they are necessary either (i) to provide for additional need arising from the development, or (ii) to compensate for its negative impact on health. If the CIL is retained, this would change the details of charging where adopted by a local authority; but the principles applying to when planning obligations are appropriate could be expected to remain broadly the same.
- 2.31 In this context, it is important to emphasise the statutory right of appeal that developers have against either refusal of planning permission or the imposition of obligations or conditions on a permission granted. In the resulting enquiry, the planning inspector would need to be satisfied that no considerations have been taken into account in the decision which were non-material. For this reason, local planning authorities always need to ensure that their policies are both based on robust evidence and formulated with sufficient precision to be applied directly to relevant development proposals.

### *Other Official Planning Guidance*

- 2.32 Further planning policy guidance relating to health can be found in other PPS documents. For example, PPS 23 on *Planning and Pollution Control* states helpfully that: *“Any consideration of the quality of land, air or water and potential impacts arising from development, possibly leading to an impact on health, is capable of being a material planning consideration, in so far as it arises or may arise from any land use”* (§8). It goes on to state (in its Appendix A) that: *“the objective perception of unacceptable risk to the health or safety of the public arising from the development ... should be considered in the preparation of development plan documents and may also be material in the consideration of individual planning applications ... ”*.
- 2.33 In contrast, health does not receive a mention in national planning guidance on housing (PPS 3), sustainable economic development (PPS 4), sustainable development in rural areas (PPS 7), or flood risk (PPS 25).
- 2.34 PPS 1 on *Delivering Sustainable Development* did provide official guidance in 2006 covering how health should be handled in LDFs. Under the subject of Social Cohesion and Inclusion, PPS 1 states that:

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<sup>7</sup> See CLG, *Planning Obligations: Circular 5/05*, supplemented by the 2006 *Planning Obligations Practice Guide*

*“Development plans should promote development that creates socially inclusive communities, including suitable mixes of housing. Plan policies should:*

- *ensure that the impact of development on the social fabric of communities is considered and taken into account;*
- *seek to reduce social inequalities;*
- *address accessibility (both in terms of location and physical access) for all members of the community to jobs, health, housing, education, shops, and leisure and community facilities;*
- *take into account the needs of all the community, including particular requirements relating to age, sex, ethnic background, religion, disability or income*
- *deliver safe, healthy and attractive places to live; and,*
- *support the promotion of health and well being by making provision for physical activity.” (§16)*

2.35 This provides a clear agenda for LDFs to address health and well-being, and health inequalities. The guidance goes on to recommend broad objectives relating to these issues to which LDFs should be addressed:

*“In preparing development plans, planning authorities should seek to: ...*

*(ii) Promote urban and rural regeneration to improve the well being of communities, improve facilities, ...*

*(iii) Promote communities which are inclusive, healthy, safe and crime free, whilst respecting the diverse needs of communities and the special needs of particular sectors of the community. ...*

*(v) Provide improved access for all to jobs, health, education, shops, leisure and community facilities, open space, sport and recreation, by ensuring that new development is located where everyone can access services or facilities on foot, bicycle or public transport rather than having to rely on access by car, while recognising that this may be more difficult in rural areas.” (§270)*

2.36 Significantly, however, PPS 1 did not explain how spatial planning was to pursue these objectives, and therefore did not itself contribute to planners’ knowledge and understanding of health issues, nor to how health outcomes could be produced. This issue emerges again in Chapter 4.

- 2.37 The direction of development of the previous government's policy can be seen in the guidance on eco-towns contained in a 2009 supplement to PPS 1 (2009), which states an intention *"to promote sustainable development by ... ensuring that eco-towns achieve sustainability standards significantly above equivalent levels of development in existing towns and cities by setting out a range of challenging and stretching minimum standards for their development"* (§7). Among other things, this is to be achieved by *"promoting healthy and sustainable environments through 'Active Design' principles and healthy living choices"* (§7). *"Eco-towns should be designed and planned to support healthy and sustainable environments and enable residents to make healthy choices easily"* (§12.1). For example, *"the town should be designed so that access to it and through it gives priority to options such as walking, cycling, public transport and other sustainable options"* (§11.1), and no-one should live more than 10 minutes' walk from health and other facilities.
- 2.38 Earlier this year the Government launched a formal consultation on a new PPS on *Planning for a Natural and Healthy Environment*. Due to be completed by 1<sup>st</sup> June 2010, this consultation was interrupted by the 2010 general election. The new government has declared an intention of reviewing and consolidating the set of PPSs, and therefore the outcome of the consultation must be viewed as uncertain, as indeed is the detailed guidance in all other PPS documents.

### *Non-Official Guidance*

- 2.39 The NHS published a *Guide to the NHS for Local Planning Authorities* in 2007. This provides a thorough overview of the NHS structure and how to engage with it, an introduction to public health principles and how they relate to spatial planning, and pointers to good practice and sources of further guidance, notably HUDU material. The most pertinent observation arising from the study is that no single planner made any reference to this guidance as a source of information on health.
- 2.40 In stark contrast, planners did quote the RTPI's *Policy Statement on health and Spatial Planning* (2007) and Good Practice Note on *Delivering Healthy Communities* (2009) as sources of information, and stated that the RTPI would generally be their first port of call for guidance beyond Government publications. The RTPI's guide both provides a thorough case for why spatial planning should be addressing health outcomes and also recommends a fairly comprehensive set of measures to be taken to achieve this. In this way, the guide provides a valuable complement to PPSs, filling some of the detail regarding how to take on a health agenda. What the guide does not address to any significant extent is how to engage the health sector in this process, particularly if the motivation for this is not already manifest.

- 2.41 The Healthy Urban Development Unit (HUDU) is a London-based body, funded by the 31 PCTs in London, whose publications have general applicability across the country, in both urban and rural areas. In the case studies, however, hardly any mention was made of HUDU outside of London. In 2007, HUDU published its *Health and Urban Planning Toolkit*, which is focussed very much on the working relationship between local health and planning bodies, setting out a practical approach to developing effective working arrangements. This used a checklist approach, as too did a later publication - the 2009 *Watch Out For Health* - which provides guidance to planners on assessing the impact of policies and proposals. A detailed exposition of the evidence base for integration of health into planning was also published by HUDU in 2007, *Delivering Healthy Communities in London*. In 2009, the Ultimate Manual for Primary Care Trusts and Boroughs was finally published, bringing together in a single volume all these guides, plus others (see Bibliography).

*Evidence Statement 1:*

*Official guidance to spatial planners makes them aware that positive health outcomes should be a strategic objective to be addressed as part of the agenda for sustainable communities. Guidance does not, however, advise them of how this should be addressed, other than through the general expectation that professional expertise should be engaged from other fields to support evidence and inform decisions.*

*The RTPi has published policy guidance on health in spatial planning, and this appears to be well known among practitioners. The comprehensive set of practical guidance published by HUDU is readily available to planners but appears to be little known outside of London.*

*Evidence Statement 2:*

*Provision with health facilities should be an essential element of local spatial planning due to their status as part of every area's physical infrastructure. Developer contributions under s106 agreements or the proposed CIL framework provide a vehicle for resource input to health facilities, and hence a strong motivation for health bodies to engage in the planning process.*

*Evidence Statement 3:*

*It is important for health outcomes to be recognised as a "material consideration" for them to be taken properly into account in planning decisions. Currently, national guidance does not provide this status. However, there is scope within LDFs for explicit policy reference to health outcomes to endow health outcomes with the status of being material to planning decisions.*

## Guidance on Local Transport Plans

- 2.42 The first guidance on local transport plans (LTPs) under the present arrangements identified a clear health objective in 2000: *“transport is an important underlying factor affecting health and LTPs should help to improve health and to tackle health inequalities”* (§13). LTPs should address health through encouraging walking, road safety and reduction of pollution. However, as in spatial planning guidance, there was no guidance on how health outcomes should be achieved. Some transport planners in the case studies described the approach to meeting Government expectations as *“mechanistic, undemanding and inwardly focused”* - a mechanistic exercise which *“never addressed health head-on”*.
- 2.43 In 2004, the second version of guidance (LTP2) required transport planning to be integrated into a framework of local spatial planning and corporate objectives across all authority functions in an area. Explicitly, LTPs should *“demonstrably address wider quality-of-life issues”* including health, and outcome indicators in these areas were expected to be established. Explicitly, *“All authorities should consider the contribution cycling and walking can make to the achievement of their plans, for example in relation to tackling congestion, quality of life and health”* (p.10). Nonetheless, the detailed requirements merely pointed towards health (e.g. in relation to the effect of emissions) but did not necessitate real action to address health directly.
- 2.44 LTP3 has changed the situation radically, expressing clear expectations that health outcomes are to be pursued directly - e.g. promotion of “active travel” - albeit with many others. This was the guidance under which current transport planners were working on their revised strategies during the case studies; and this encouraged a favourable comparison with the much weaker and more indirect promotion of health in official planning guidance.

### Evidence Statement 4:

*The bulk of policy guidance on local transport plans (LTPs) is found at any time in a single document. This guidance has signalled the importance of health outcomes for several years, but the expectations of direct action in this respect are now much more explicit in the latest guidance for LTP3.*



## Guidance on Health

- 2.45 In the review of guidance to planners, a clear message emerged that those responsible for preparing spatial planning documents at local and regional levels may be expected to engage health bodies in their decision-making processes as both stakeholders and delivery agents, even if they are not always statutory consultees. It is perhaps surprising, therefore, that there appears to be no equivalent formal guidance from the Government to health bodies on how to engage with the planning system.
- 2.46 The overall volume of policy and other guidance in the health sector is, understandably, very considerable. Within this, however, there is extremely little that makes direct reference to spatial planning. Most of the formal guidance is of an indirect nature, i.e. guidance on health involvement in processes that relate strongly to spatial planning, but not on engagement with spatial planning itself. This is despite a considerable amount of guidance being published on health inequalities and wider public health issues that relate to phenomena with which spatial planning is strongly engaged: housing, transport, greenspace, pollution, etc. Recognition of how these factors can and do contribute to health has not really been translated into strong and clear policy guidance that health organisations should be engaging with decision-making processes in the planning system.

### *The National Health Agenda*

- 2.47 A series of documents issued by the Department of Health (DH) have established a national agenda for a more holistic approach to health: embodying it into a wider concept of wellbeing, and placing emphasis more on prevention than on the treatment of ill-health. In other words, attention should be placed on the determinants of health, and measures to address these developed through a public health framework. This is perhaps most easily identified in the requirement for joint strategic needs assessment (JSNA) to be undertaken to identify local needs in relation to communities' health and wellbeing (see §2.58).

### *Sustainable Community Strategies*

- 2.48 This is best illustrated in relation to Sustainable Community Strategies (SCSs) as set out in the *Local Government and Public Involvement in Health Act* of 2007. PCTs are expected to be directly engaged in the production of the respective over-arching SCS in every part of the country, namely as:
- member of the Local Strategic Partnerships (LSPs),
  - joint deliverer of the Local Area Agreements (LAAs - see §2.66) and

- body having joint responsibility with the local social care authority for production of the local Joint Strategic Needs Assessment (JSNA - see §2.58) - for health and wellbeing, which is intended to inform the SCS.

Yet there is effectively no real health guidance for PCTs to engage in the local spatial planning processes that are equally important in delivering the SCS - specifically the production of the Local Development Framework (LDF). Considering that the SCS is a primary source of strategic guidance on objectives and priorities for LDFs, this represents a golden opportunity for PCTs in particular to influence local spatial planning.

### *Commissioning of Healthcare Services*

- 2.49 This can be viewed as the activity which absorbs most of PCTs' human and financial resources, and hence constitutes the bulk of its core business. As characterised in the current agenda for World-Class Commissioning<sup>8</sup>, it is essentially focussed on ensuring the provision of personal services to individual clients in terms of the quality and quantity. This focus on individuals does not readily lead to recognition of a significant role for spatial planning; and there is certainly no direct reference to it in the documents providing formal health guidance. Practitioners at the workshops underlined the fact that the national agenda for World-Class Commissioning did actually require a partnering approach, but that it did not specify that this should include liaison with spatial planning bodies; it also sets out the need for an intelligence function (see also the discussion of JSNAs in §2.66), but this could be *"weak and fragmented"*.
- 2.50 In health guidance, however, there are references to the provision - and hence location - of health facilities, to accessibility, and to housing and other phenomena that may be influenced through formal spatial planning. Furthermore, acknowledgement of the potential value of analysis in terms of social groups and geographical communities could also help recognise a possible agenda for engagement with spatial planning. Nonetheless, official guidance on health commissioning has typically not followed such potential links to the attribution of any significance to spatial planning.
- 2.51 At the same time, there has been increasing emphasis on PCTs coordinating their commissioning of health care services with local authorities' commissioning of social care services. In bringing PCTs and local authorities responsible for adult social care into close cooperation, joint commissioning could also provide a route through which PCTs find engagement with spatial planners. However, this would only apply in metropolitan boroughs and other unitary authorities; for in the shire districts responsibility for social care

<sup>8</sup> For example: DH, World Class Commissioning: Vision, 2007

lies with the county councils, and planning with the districts. Moreover, official guidance on social care places no greater incentive for engagement than it does on health bodies.

### *Public Health*

- 2.52 It is much easier to recognise the potential for PCTs' responsibilities for public health providing a motivation for contact with spatial planning. Official guidance focuses on the agenda for prevention of ill-health, and hence on the determinants of ill-health. Since many of these relate to housing conditions, various forms of pollution, social exclusion, and other factors to which spatial planning also pays particular attention, it might be assumed that engagement with the spatial planning process might be an almost automatic step. Yet this step is conspicuous by its absence in the recommendations found in official guidance.
- 2.53 Public health guidance tends to be structured around various individual conditions or determinants of ill-health, such as smoking, obesity, alcohol harm and so on. Actions are recommended with regard to engaging with individuals, communication and education, and engagement with public services directly involved in the subject. It is a characteristic of spatial planning that it is typically at one remove from direct involvement with individuals: it provides the overall framework within which other bodies will be acting in their design of roads, housing estates, and so on. This may be the reason why the potential for spatial planning to exercise positive influence on these activities is not being recognised.
- 2.54 In line with the Government's long-standing agenda for promoting choice in public services, guidance on public health stresses the importance of interventions to promote "*healthy choices*", essentially by changing an individual's environment and perceptions so that they choose behaviour that leads to healthier outcomes for themselves. This guidance does not generally attribute a role to spatial planning in this agenda - as demonstrated, for example, in two of three independent reports published by the Department of Health in February 2010<sup>9</sup> and intended to inform Ministers in their consideration of future policy guidance. The third report - *Enabling Effective Delivery of Health and Wellbeing* - does at least refer to planning as a factor; however, the reference here is to "planning regulations" representing a "barrier" to achieving maximum health gain.

### *Health Inequalities*

- 2.55 One aspect of public health which needs to be treated independently is the issue of health inequalities. While inequalities may be frequently addressed as they apply to social groups and even individuals, there appears to be a ready recognition in health guidance that they

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<sup>9</sup> DH, *A Liberal Dose? Health and Wellbeing*

often take on a geographical dimension, and particularly where they are related to other inequalities experienced in recognised areas of deprivation.

- 2.56 The potential role of planning was acknowledged in the Government's 2002 *Cross-Cutting Review into Health Inequalities*, for instance in the need for *"improving accessibility of disadvantaged groups to core facilities .... through better land use planning"* (p.15). Nonetheless, a review of subsequent official guidance from the Department of Health reveals a strong tendency for the actions being promoted to lie in the realm of commissioning, service provision and facility planning - in other words, within the PCTs' own responsibilities<sup>10</sup>. Government guidance has generally not been urging PCTs to engage with spatial planners.
- 2.57 Recent advice to Government has nonetheless been clearly promoting the benefit of health and spatial planning authorities being involved in a joint effort to address health inequalities. The Marmot Review published in February 2010, for example, made a policy recommendation to *"[f]ully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality"* (p.30).

### *Joint Strategic Needs Assessments*

- 2.58 Government guidance to all public sectors promotes the notion that policy development should be based upon sound evidence, and this principle is well established in both spatial planning and health. It was noted above (see §2.31), for instance, that the evidence for spatial planning policies can be challenged not only in the process of formal approval, but also through appeal whenever it is used to refuse applications for development.
- 2.59 While this scope for challenging evidence may not be a significant feature in the field of public health, there is nonetheless a strong imperative to seek a robust evidence base for policies. This is clear from the publication by the Government (CLG) in 2008 of *Creating Strong, Safe and Prosperous Communities: Statutory Guidance*, which provides guidance on Joint Strategic Needs Assessments (JSNAs), Local Area Agreements (LAAs - see §2.66), Sustainable Community Strategies (SCSs), and their interrelationships.
- 2.60 Here it is JSNAs that are of particular significance - for a duty to undertake JSNAs is shared between PCTs (the Directors of Public Health) and those local authorities responsible for social care and support services. The statutory guidance (§3.28) states:

*"This assessment should set out the future health and social care needs of local populations. The assessment should cover those issues where the responsibilities of*

<sup>10</sup> For example: DH, *Health Inequalities: Progress and Next Steps*, 2008

*PCTs and local authorities overlap or where one organisation in carrying out its functions impacts to a significant extent on the other organisation's functions".*

- 2.61 This is an extremely positive statement of a requirement for health issues to be taken into account when they may be affected by decisions taken by a local authority. Any inference that this applies only to upper-tier authorities - i.e. county councils in two-tier areas - could be seen to be countered by a clarification in the guidance:

*"In two-tier local authority areas, upper tier local authorities will need to consult with those district councils within their geographical area" (§3.29).*

This can be seen to bring the district councils as spatial planning authorities into the JSNA framework, in that any potential impact of their planning decisions on health issues should be addressed in a JSNA in accordance with this guidance. Unfortunately, however, the use of the term "consult" leaves some ambiguity in this respect.

- 2.62 In the guidance note *Delivering Health and Well-Being in Partnership: The Crucial Role of the New Local Performance Framework, 2007*, the Department of Health stresses the potential practical importance of how the JSNA should be handled: *"Government Offices (GOs) overseeing the LAA negotiations will look for assurances that the outcomes of the JSNA have been fully considered in agreeing LAA targets"* (p.5). This ought to have considerable significance for LDFs in practice.
- 2.63 From the perspective of a PCT, once needs for health and wellbeing have been articulated in the JSNA, they should be fully reflected in the Sustainable Community Strategy, and hence in the LAA which sets out targets to which the PCT should be working. However, if these needs also required a complementary spatial planning response, this response would need to be established in the respective LDF. Moreover, the responsible Government Office should presumably check this before agreeing any related LAA targets on the basis of the needs having been "fully considered". In other words, there should be an assurance of continuity - at least through the involvement of the respective government office -between SCS, LDF and LAA in relation to needs identified in the JSNA. Consequently, its joint responsibility for the latter should give a PCT potential leverage to influence the coverage of health issues in the LDF. Despite this, the DH guidance note does not refer to LDFs, but only to the link between JSNAs and LAAs. A similar pattern emerges in other guidance documents, such as *The NHS in England: the Operating Framework for 2008/9* (2007): while urging PCTs to engage with local authorities and local partnerships, makes no explicit reference to any involvement in spatial planning.

### *Guidance to Health Professionals on Planning*

- 2.64 In 2007 the NHS published a Guide to Town Planning for NHS Staff. This provides a fairly comprehensive but generalised view of the spatial planning system, together with some useful suggestions about how to engage with the system. Perhaps more significantly, the guide sets out a strong case for why health bodies should be engaging. It states that *“the NHS needs to get involved in the planning system so that they can influence:*
- *regional and local policies to take health into account;*
  - *planning obligations - to secure any necessary contributions from developers towards the cost of additional healthcare facilities arising from a new development;*
  - *the development potential of their own land and buildings (for health service or alternative uses) by having them included within the local policy framework.”*
- 2.65 Most HUDU publications (see §2.41) are aimed at both planners and health professionals, and they provide a much more detailed set of guidance - indeed the NHS guide makes reference to HUDU's publications. Two documents from HUDU in particular are geared very much to assisting health bodies engage in the planning process: the more general *Integrating Health into the Core Strategy: A Guide for Primary Care trusts in London*; and the web-based *Planning Contributions Tool*, which enables the calculation of contributions to compensate for health impact from proposed developments.

#### *Evidence Statement 5:*

*National policy guidance to health professionals does not explicitly require them to engage in spatial planning processes. However, it promotes policies which necessitate action on the determinants of health as an effective means of achieving health outcomes, which implies a role for spatial planning as a potential vehicle for effective interventions. A NHS practice guide does make a very strong case for engagement by PCTs in the spatial planning process.*

## Local Area Agreements

- 2.66 Each unitary authority and county council is under a duty to work with other public-sector partners - notably the PCT in this context - to enter into a Local Area Agreement (LAA) to determine targets for local improvements of a period of 3+ years in its area. While this is not a part of a LDF, the LAA is likely to be a critical and complementary vehicle for delivering the LDF - particularly elements not directly connected to development and land

use - through its function in helping to bind these public-sector delivery organisations into a common strategy. This should be clear from the preceding discussion relating to JSNAs.

2.67 The Government makes clear that spatial planning has an important role to play in the delivery of LAA targets. In *Planning Together*, CLG describes planning's contribution as being "*parks, recreation and sports provision, transport, walking and cycling, air quality, access to goods and services, strong economies and access to employment; planning for a range of quality accommodation including affordable and lifetime homes*" (p.14). However, this could be seen as misleading if not tempered by two key facts:

- firstly these are all areas in which planning seeks to exert a positive influence by facilitating and encouraging others to deliver the desired change, rather than developments which planning itself actually delivers;
- secondly, this is a list of amenities and factors which can contribute to health and wellbeing, but which are very much dependent on other factors, notably the behaviour and choices of those potentially involved.

2.68 Guidance makes clear that health and wellbeing are important targets for local action, as signified by the outcome targets to which LAAs should be addressed. A critical feature of these arrangements, however, can be seen when looking at a district or borough council within a county council area. Even though, as a public body, it is part of the delivery mechanism for the LAA, the measure of delivery is applied over the whole county, not to any subsidiary district in particular. In contrast to the situation in a unitary authority area, this makes the relationship between LAA and LDF far more tenuous.

#### *Evidence Statement 6:*

*Government guidance on JSNAs requires them to cover areas of need for health and wellbeing which are potentially influenced by spatial planning decisions. PCTs are jointly responsible for JSNAs and also members of LSPs, which should address the needs identified in formulating SCSs. PCTs' involvement in delivering LAAs should require a degree of coordination with LDFs, which are the spatial manifestation of SCSs. Implicit in these arrangements is a need for the decision-making processes for JSNAs, SCSs, LAAs and LDFs to be coordinated, and hence for an engagement between health and spatial planning. This presents a particular challenge of communication and coordination in two-tier local authority structures, where the LAA relates to the county area, and spatial planning is the responsibility of boroughs and districts.*

## **Local Government Act, 2000**

- 2.69 This act, together with other related documents that were subsequently issued by the Government, had a momentous effect on local authorities with respect to their internal operations and structures, their accountability for performance, and the status of their working with other bodies through local strategic partnerships (LSPs). However, from the perspective of this research project, potentially far more fundamental was the responsibilities given to local authorities for the promotion of their communities' social economic and environmental wellbeing. It imposed a duty on them to produce a strategy aimed at achieving this, and it also granted powers to local authorities to undertake any steps they consider appropriate and lawful to this end.



### 3 Document Reviews of Current Practice in Planning

- 3.1 In parallel to the review of the national policy framework, a review was conducted into documentary evidence of how this framework had been applied in practice. In spatial planning, the focus was on regional spatial strategies (RSSs), and local development frameworks (LDFs). In terms of the health sector, the review sought to identify - primarily from national sources - any local attempts to integrate health into spatial planning. The questions posed in the reviews are given in Appendix A.

#### Regional Spatial Strategies

- 3.2 Each region now has a spatial strategy (RSS) - although those for the South West and West Midlands have not been finalised and adopted<sup>11</sup> - and it was possible to review all of them in the study. This section provides an overview of the results.
- 3.3 Each RSS had been created after the new spatial planning arrangements were put into place in 2004, and therefore should reflect the expectations imposed upon them in the respective legislation and formal guidance. All but two were submitted in 2005-06, with preparatory work extending back into the period before the new arrangements came into force. Their examinations in public (EiPs) by the Planning Inspectorate, and the revisions following this, had occurred over the subsequent period, extending into 2010 in the case of the West Midlands Plan. This had meant that it ought to have been possible for the growing awareness of spatial planning's potential impact on health and wellbeing to have been brought to bear in each case before finalising the policies and other provisions contained within the strategies.

#### *Strategic Objectives aimed at Health Outcomes*

- 3.4 Among the "visions", "principles" and objectives set out as providing guidance in the individual RSSs is a wide variation in how the subject of health is treated. At one extreme, in those of the South West and Yorkshire & Humber, there is no specific mention of health. In contrast, both London Plans - i.e. the 2008 version and the draft revision of 2009 - place considerable emphasis on health outcomes, and particularly on addressing health inequalities in the capital. The first objective in the Draft Replacement Plan specifically aims *"to help tackle the huge inequalities among Londoners, including inequality in health..."*.

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<sup>11</sup> These processes will not take place now, given the Government's intended abolition of regional strategies.

### *Consultation on Health in Developing the Strategies*

- 3.5 All documents used substantially in the development of RSSs had been made available to the public up to and during the respective EiP. Subsequently, however, such documents were no longer generally available, and therefore it was rarely possible in the research to track the influence of how health issues had been handled in the preparation of each RSS.
- 3.6 In particular, it was difficult to establish through available documents the level and nature of direct Input from PCTs or other health bodies into the decision-making processes behind each RSS. Subsequent interviews with individuals involved did suggest that active involvement of health interests may have occurred throughout the processes to produce RSSs in some regions, for example through the Regional Public Health Groups and regional officers of the Health Development Agency before this body disappeared; however, it was not possible to interpret how focussed and effective such involvement may have been.
- 3.7 The statutory consultation on draft RSSs certainly appeared to have brought engagement from the health sector in at least some regions, as evidenced through issues recorded as having been addressed in the EiPs in reports from the Panels of Inspectors. For example, in the East Midlands the Panel inserted the term “building a strong and healthy society” into the vision for the strategy, and it also required “health” to be defined to include “mental, physical and spiritual well-being”.

### *Health Facilities as Part of the Infrastructure*

- 3.8 Infrastructure figured large in the considerations of sustainability in RSS documents. Where the infrastructure was defined or described in any detail, health facilities were included among these. This did not apply to all regions, but the pattern was sufficiently strong to suggest that health facilities could be assumed to be in the minds of planners when referring to infrastructure - i.e. that it was implicit where not mentioned.
- 3.9 It appeared to be widely accepted that, while a RSS might promote and facilitate provision with infrastructure in general, and health facilities in particular, it did not at the same time determine that investment to produce it would automatically follow. For example, the West Midlands RSS specifically stated that successful implementation of the strategy “... requires integrating land-use decisions with other activities (such as education, health, community safety, leisure and environmental services) ...”; and it specifically stated a purpose of influencing investment and provision by health providers. In the Draft Replacement London Plan, Policy 3.18 addressed this head-on, stating that “*Boroughs*

*should work with the NHS [and] social care services... to assess the need for healthcare facilities....and to secure sites for future provision or reorganisation of provision”.*

### ***Policies to Deliver Health Outcomes***

3.10 Other health-related policies fall generally into three broad categories:

- Attempting to change individual behaviour to achieve a health outcome -
  - [local planning authorities should] *“increase access to green space that can be used for formal and informal recreation, educational purposes and to promote healthy lifestyles.”* (East Midlands Plan, Policy 28)
- Using health outcomes to change other behaviour - e.g.
  - *“To bring about a significant change in travel behaviour, a reduction in distances travelled and a shift towards greater use of sustainable modes, regional and local authorities, transport providers and other delivery agencies should implement policies to: ... raise awareness of the health benefits of travel by non-motorised modes.”* (East of England Plan, Policy T2)
- Avoiding negative health impact - e.g.
  - *“In implementing the overall vision and objectives of the Regional Spatial Strategy waste management policies should be based on the following objectives: .... to minimise the environmental impact of waste management, including impacts arising from the movement of waste, and help secure the recovery and disposal of waste without endangering human health.”* (East of England Plan, Policy WM1)

3.11 In some cases, the reference to health as an outcome of a policy left much to be desired in terms of understanding the causal link to what was being proposed. Policy LCF1 in the South West, for instance, required that *“locally important cultural facilities will be protected and enhanced, with provision for new or improved facilities made to ensure the health and well-being of the population.”*

3.12 Few examples were found of policies addressing health inequalities. One in Yorkshire and Humber, Policy ENV7B, states that *“development or use of agricultural land in appropriate locations will be encouraged for ... outdoor recreation projects, especially in areas of poor health in South and West Yorkshire”*. Similarly, the Draft Replacement London Plan required investment to be coordinated in *“physical improvements in areas of London that are deprived, physically run-down, and not conducive to good health”*(Policy 3.2 B).

### Health Impact Assessments

3.13 Sustainability Appraisals (SAs) are one type of document still readily available from RSS processes, and health issues appear in all of the assessments, some specifically having used a HIA. The language used in the SAs suggested that it had been the intended outcomes of RSS policies, not the policies themselves, which had been assessed. In other words, the assessment undertaken had been whether the intended outcome would either impact positively on health or accord with a strategic objective relating to health. There was little evidence of any assessment made of (i) whether the policies in question might actually deliver the intended health outcomes, or (ii) how likely it was that the policy might be implemented. The implication of this is that HIAs might be of limited value in judgement of whether the correct or best policies have been included in a RSS.

3.14 This can be illustrated in an extract from the SA of the East Midlands Plan:

*"Appraisal against the health SA objective shows that the Regional Plan is generally expected to result in positive cumulative effects. The Plan encourages walking and cycling and the provision of green infrastructure, along with encouraging sport and protecting the natural environment, which are all likely to impact positively on health (although the delivery of sustainable transport measures is uncertain). This may lead to reductions in air quality and therefore potential negative cumulative effects on public health."* (p.68)

3.15 The SA for the North West even included a comment which itself raised questions about the value of assessment at the regional level: *"Health is generally and strategically considered in the RSS but there is a need to recognise that health effects are felt at the local level, not the regional level"* (p.97). This example, however, may be seen to reflect the difficulty assessors have in quantifying some impacts at larger scales, particularly where inequalities are measured at ward level. In contrast, there are some health outcomes which are experienced regionally, for example the effects of hard and soft water.

### How strongly does a RSS influence LDFs?

3.16 In the study, RSSs were examined in terms of what policy content that would have to be taken into account by local planning authorities in spatial planning decisions within their LDFs. For example, in the Draft Replacement London Plan, the policies were differentiated between those which required *"strategic action"* - by implication, London-wide, or outside of LDF frameworks - and those which needed to be considered in LDF preparation: for example, Policy 3.17 stated that *"LDFs should provide a framework for collaborative engagement with social infrastructure providers..."*.

*The London Plan (Draft Replacement Plan 2009) provides the strategic context for health and spatial planning in London and was currently at the stage of Examination in Public during the research. It has clear objectives for improving the health of the population and reduction of health inequalities and proposes partnership working with the London Strategic Health Authority, PCTs, foundation trusts, LSPs and voluntary and community organisations involved in delivering health services.*

*There is supporting text on NHS models of care, the assessment of need for social infrastructure, their accessibility, the economic importance of health in London as a centre of excellence, and its employment role. It requires that DPDs should set out preferred locations for new health facilities, require HIAs for major development proposals, and sets out which "policies within the Plan have a part to play in promoting good health and seeking to address inequalities in health" (§ 3.112).*

*The Plan provides separate policies on addressing health inequalities (Policy 3.2.1), protection and enhancement of social infrastructure (Policy 3.17), and healthcare facilities (Policy 3.18). Each of these provides guidelines on what the Mayor will do, criteria for planning decisions, and what is required in boroughs' LDF preparation.*

- 3.17 Where an RSS policy required LDFs to ensure that health facilities were provided as part of the infrastructure, the principle to which the local planning authority should address its own decision-making was obvious. Absence in the policy of any detail regarding standards or other aspects of intended provision would not normally be viewed as a failing, since such issues would normally be determined at the local level in consultation with local partners. In London, the Mayor had attempted to supplement policy guidance in the strategic plan by issuing the *Mayor's Best Practice Guidance on Health Issues in Planning* (2007).
- 3.18 In some strategies, there was an acknowledgement that the RSS was not the only determinant of LDFs. In the West Midlands RSS, this was confirmed in its guide to local authorities regarding LDF conformity with the RSS: "*Community Strategies are prepared by all councils in response to the priority concerns expressed by local people. Many of these concerns will relate to such things as crime, old people's welfare or health promotion that **can't be tackled through the formal development planning process***" [p.1, author's emphasis]. This statement actually appeared to deny any role for spatial planning in the promotion of health. While the areas mentioned were clearly influenced by many factors lying outside the direct influence of spatial planning, the notion that the LDF and RSS might have no ability to influence them would undermine this study and could easily be challenged.
- 3.19 Where the objective was to achieve outcomes in public health and wellbeing, the actions required within LDFs was much less clear than had been the case where policies related to infrastructure. When outcomes were expressed as "improving health", "healthier lifestyles", or similar, this left questions such as "by how much?", and "how quickly?". If a policy

referred to “promoting health”, “encouraging” development, or “minimising impact”, there would be a danger that it could be seen as completed and effective once these things had taken place, regardless of whether any positive benefit had arisen from this. In both these cases, there was no reason to infer any cynicism on the part of those formulating the RSS policies. Nonetheless, these ambiguities suggested that the many references to health contained in RSS documents across the country might not automatically translate into a strong imperative for positive action within LDFs.

3.20 In this context, it is worth quoting at some length from the South West Plan:

*“LDDs should ... take into account Health Impact Assessments and advice on public health in order to maximise the opportunities for tackling the root causes of ill health through well-planned development. Local authorities should seek to ensure that development promotes opportunities for health enhancement and should conduct local needs assessments to ensure that plans for service and facility provision meet the needs of the people. In those wards of the South West performing least well in relation to measures of health inequality, local authorities should have particular regard to ensuring positive health outcomes from development.” (§6.2.7)*

*“LDFs should support proposals for the provision of additional healthcare facilities where clear need exists. Local authorities should work with the NHS to ensure that a health needs assessment for the prospective population has been undertaken. ... Working with healthcare providers, local authorities should seek to ensure that all healthcare is provided in locations which are accessible to all users by public transport, on foot and by bike, and that it is of the highest design quality. Healthcare requirements arising from large-scale development and redevelopment should be assessed and adequate provision of facilities included in the master plans and design briefs required under Development Policy F, particularly for new strategic urban extensions where new populations could put undue strain on existing facilities.” (§6.2.8)*

*“Planning for future healthcare provision must consider the longer-term population and demographic implications of the scale of change this Draft RSS is addressing. ... Local authorities should work closely with healthcare providers ... to ensure that plans for the growth and reorganisation of healthcare within their area and that of adjacent authorities are fully complementary with plans for development and change in the long term.” (§6.2.9)*

3.21 The significance of these quotes was that they were taken from the supporting text of the RSS, and not from the formal policies with which LDFs would have to comply. Together, they did set out a quite comprehensive strategic approach to the health issues to be taken forward in LDFs. Yet, because they did not carry the force of formal RSS policies, they were not requirements with which LDFs had to conform.

### *Monitoring Outcomes*

- 3.22 One means of judging how seriously health outcomes might weigh in the delivery of RSSs was through an examination of their monitoring frameworks. In most regions, indicators of the region's health were either absent from annual monitoring reports (e.g. the North East) or they were limited to basic indicators of public health such as obesity levels (e.g. the South West). Indirect indicators might be of general interest, but they provided no feedback on whether RSS policies had been either implemented or effective. Indeed, the approach to monitoring may be explained through a comment in the final SA of the East Midlands Plan: *"As no significant negative effects on health have been identified in the Sustainability Appraisal, proposals for monitoring have not been included"* (§9.7).
- 3.23 Some regions were monitoring changes in health inequality - e.g. the South East - but here it was equally unclear whether and how such changes were to be interpreted as resulting from RSS policy implementation. In only one region - Yorkshire & Humber - did the annual monitoring report include information on whether the actual health-related policies were being applied in LDFs.

#### *Evidence Statement 7:*

*The current set of RSSs provides ample evidence of health being on the agenda of spatial planning at that level. Treatment of health is, however, far from uniform, and particularly with respect to any inclusion of policies setting out expectations for health to be addressed in the subordinate LDFs. Where such policies are included, they do not provide clear guidance on how health issues are to be addressed. The recent Government announcement of an intention to abolish the regional level of spatial planning has seriously reduced the relevance of these findings. However, they do indicate how health might be handled in the future if there were any higher-order strategies able to influence local spatial planning.*

#### *Evidence Statement 8:*

*HIAs undertaken on RSSs might have been considering the impact of the intended outcomes of policies, and not the impact of the policies themselves. This may have undermined decisions on policies which relied on the HIAs.*

## Local Development Frameworks

- 3.24 The purpose of this review was to provide an initial insight into how health has been dealt with in LDFs through recent work on Core Strategies and related documents. Unless

otherwise indicated, the comments on LDFs refer to Core Strategy documents. In particular, it was undertaken with a view to identifying appropriate candidates for case studies and appropriate research questions to pose. The selection of LDFs for review is explained in Appendix B.

### *What is meant by Health in LDFs?*

- 3.25 The LDFs which were reviewed tended to bring together two broad issues under the topic of health: promotion of healthier lifestyles and better access to healthcare provision. Although these two issues required very different responses in terms of spatial planning, LDFs were not always drawing out this distinction. In the majority of cases health infrastructure needs were clearly set out; but how healthier lifestyles would be promoted was typically much less clear.
- 3.26 Most LDFs recognised that there was a much wider range of factors contributing to the health of a population than simply the access to health facilities. These wider factors ranged from feeling safe in one's community to improving air quality and tackling climate change. Some LDFs mentioned mental health and wellbeing too, e.g. Sutton's identified these as being included in the "wider determinants of health".

### *LDF Objectives and Priorities relating to Health*

- 3.27 Health was always found to be a theme in the respective Sustainable Community Strategies (SCSs), but its significance in LDFs - for example, whether it was a priority - was more variable. This appeared to depend on the characteristics of the local population, for example whether the area was generally prosperous with small pockets of deprivation, had much higher deprivation and hence health inequalities, or had an ageing population. Health priorities were often set out more explicitly in SCSs than in LDFs; and in the latter they varied from being an explicit objective or priority to being more implicit elements in improving the quality of life.
- 3.28 In the New Forest District, for example, there was consistency between the SCS and LDF in terms of general objectives, such as *"more people will lead healthier lifestyles"*. However, specific objectives set out in the SCS - such as reducing the number of people who smoke, reducing obesity and fostering higher self esteem in young people - were not directly taken up in the LDF. This may have been attributable to a view that spatial planning had nothing to offer on some specific health issues; yet that would have been inconsistent with the promotion of higher use of walking and cycling to help reduce obesity as embodied in the RSS policies with which the LDF was to conform.



- 3.29 For all the LDFs studied, the decision-making processes had considered health under the baseline analysis (usually under population); and most of them appeared to have recognised health issues as being among the major challenges in the area, although not always explicitly. Health inequalities were often flagged up as being significant - either in general, e.g. that life expectancy was lower than the national average (Barking and Dagenham), or in pockets of poor health in urban areas (Stoke) or in more isolated rural communities (northern parts of East Cambridgeshire).
- 3.30 A key theme in many LDFs studied was the “promotion of healthier communities”, picking up the objectives and policies of the respective RSS. This phrase was not usually defined, although it was often accompanied by reference to specific objectives that could be inferred as having positive health outcomes: more active lifestyles, more walking/cycling, access to greenspace or sports and recreation facilities, reducing need to travel, addressing derelict/contaminated land, providing allotments, supporting markets for fresh produce, etc.
- 3.31 Particularly in more rural districts (Mole Valley, New Forest, Northumberland National Park) there was significant emphasis placed on improving and preserving the “health” of the natural environment, with implied benefits for the well-being of the resident population. Some explicitly linked the range of policies back to the objective of healthier communities; in others, the link had to be inferred by the reader.
- 3.32 In contrast to the case of RSSs (see §3.5), health did not appear separately as an issue to be discussed in the EiPs for the sample of LDFs. Inspectors’ reports did highlight health issues, although they were referred to in relation to social infrastructure (its justification, etc.) in some cases. In one case (Sutton), health issues were mentioned in relation to the changes required as a result of representations submitted by the local PCT. The Inspector for Southampton’s Core Strategy commented favourably on Policy CS10, which required HIAs to be undertaken on major schemes, but required a wording change from “significant” to “major” schemes to clarify that they should not be undertaken on smaller schemes.

### *Policies to Promote Health and Wellbeing in the LDFs*

- 3.33 Only one of the LDFs reviewed contain a formal policy on health - policy CS10 for “A Healthy City” in Southampton’s Core Strategy. The majority of LDFs did not explicitly consider health to be a key objective. This, however, did not mean that health issues were not covered. The depth of coverage of health issues was not always related to specific concerns or to levels of deprivation. Some relatively affluent areas prioritised health as an issue, e.g. Sutton.

### *LDF Policies relating to Health Facilities*

- 3.34 Improved and better access to healthcare facilities was, however, always included in LDF objectives or in policies. It was usually referred to as one part of social or community infrastructure (with education, community buildings, etc.). Some LDFs gave health provision more prominence - e.g. North Staffordshire. The extent to which healthcare facilities featured in discussions of infrastructure provision appeared to depend on the current or projected shortfall in provision. It was frequently noted that, to respond to growth, existing healthcare facilities would need to be improved and/or expanded and new ones provided in a timely manner in areas of new development.
- 3.35 Accessibility to healthcare facilities was a key issue for urban and rural areas. However, it was more often cited as an issue in rural areas where transport was viewed as a significant problem. There was a recognition that ensuring facilities were closer to people was a national health priority; and therefore policies were common to ensure that facilities would be provided in accessible district or key service centres. The New Forest Core Strategy, for example, noted that some towns lacked a GP or NHS dentist. The Wokingham Core Strategy went a step further, identifying the need to make the borough's hospitals accessible by public transport.

### *Involvement of Health Organisations in Decision-Making*

- 3.36 Many LDFs expressly mentioned the local PCT. From the documentation, however, it was not always apparent how closely, nor at what point in the process, the PCT had been engaged in the preparation of LDF policies - even when, for example, the PCT's Health and Wellbeing Strategy had been listed as part of the evidence base for Southampton's Core Strategy. In some cases, there was reference to the local authority and PCT having jointly developed a delivery strategy for health facilities in accordance with the LDF, e.g. Dover, Poole and North Staffordshire.
- 3.37 Crucially, evidence drawn from the LDF documents provided a clear impression that the emphasis of the consultation process with health organisations had been on planning for healthcare facilities, rather than on health improvement or inequalities.

### *Delivery Mechanisms for LDFs*

- 3.38 Some LDFs make specific provision for health facilities in their delivery framework and/or infrastructure investment plan. Among those which did not, there was often an indication given that these details would appear later and in consultation with the local PCT.

***Evidence Statement 9:***

*The sample of LDFs demonstrates that the pursuit of health outcomes has been accepted as a legitimate issue to be addressed in local spatial planning. Health features both explicitly and implicitly in objectives and policies. Promoting healthier communities was a theme found in both prosperous and deprived areas, and better access to healthcare provision was a common objective or policy. While most LDFs acknowledged that policies and other factors impact on health, the implied causal links between policies and outcomes were generally neither strong nor explicit. The respective PCTs appeared to have been engaged to varying degrees in core strategy preparation but relating to the practicalities of providing facilities, rather than to policies promoting healthier lifestyles or addressing health inequalities.*

## Health Initiatives

- 3.39 A series of official health initiatives were encountered through the document review, permitting a range of areas across the country to be identified in which, in keeping with their designation within the initiatives, it might be expected that health professionals might have engaged with the spatial planning system.

### *“Healthy Cities” (WHO programme)*

- 3.40 This programme had been operational for several years. In it, cities around the world had been nominated and designated for recognition as “healthy cities”. What this meant was set out in the official publication *Phase V (2009-2013) of the WHO European Healthy Cities Network: goals and requirements*, 2009:

*“Throughout its evolution since 1988, the heart of Healthy Cities remains the four overarching action elements on which it was founded:*

- *action to address the determinants of health, equity in health and the principles of health for all;*
- *action to integrate and promote European and global public health priorities;*
- *action to put health on the social and political agenda of cities; and*
- *action to promote good governance and integrated planning for health.” (p. 1)*

*“The overarching theme for Phase V is health and health equity in **all local policies**. Health in all policies is based on a recognition that population health is not merely a product of health sector activities but **largely determined by policies and actions beyond the health sector**. ... Solid evidence shows that the actions of other sectors beyond the boundaries of the health sector significantly influence the risk factors of major diseases and the determinants of health.*

*... Cities will be expected to work to systematically promote the active engagement and the **collaboration of different sectors in the pursuit of health outcomes**. They will explore and introduce **governance measures that facilitate intersectoral collaboration** for health and health equity, planning approaches that support integration and mechanisms ... emphasizing action **addressing the social determinants of health and inequality in health**.*

*... Cities will be encouraged to introduce and **apply evidence-based interventions**... The concept of the **city health development plan** (or the equivalent) remains valid and desirable, encompassing the emphasis on **integrated planning and strategic thinking**.” (pp. 2-3, author’s emphasis)*

- 3.41 At least 10 English cities (or boroughs) could be identified as having been accepted onto the WHO programme. It was to be expected that any of them should be actively in the process of integrating health objectives into its corporate working, and hence into its plans and strategies, including spatial planning. In most cases, documentary information from the locality suggested that the activities being undertaken were not directly involving the spatial planning system in any significant way.

### ***Healthy Communities (IDeA programme)***

- 3.42 The objectives and criteria for inclusion in this IDeA programme appeared to be much looser than for the WHO. Unfortunately, again no definitive list could be found of areas included. Nonetheless, it was possible to identify examples (sometimes “case studies”) on the IDeA website where an objective reportedly being pursued included a statement along the lines of “*integrating health objectives into the objectives and activities being pursued across all council departments*”. If this reorientation of all council departments to ensure coverage of health issues could be achieved, it offered hope that spatial planning would embrace health in a meaningful way.
- 3.43 Four local authorities could be identified with such an objective under their Healthy Communities programme. However, as with the WHO programme, these authorities did not emerge through further documentary research as having undertaken anything special in terms of linking health to spatial planning.

### *Specific Examples of Health in Planning*

- 3.44 Via IDeA's website and further sources, other specific cases were identified where there appeared to have been a local initiative to pursue the objective of "health in planning" or similar. Five were identified, and one of these - Tower Hamlets - emerged from documentary research as an area worth considering as a case study.

### *Beacon Councils for Health Inequalities (IDeA)*

- 3.45 Not a health initiative as such, this was the award in 2008 of recognition for progress already achieved in tackling health inequalities. Unfortunately, documents relating to the six authorities revealed almost no mention of the planning system having been used to a significant degree in their achievements.

### *Sustainable Travel Towns Programme (Dept. of Transport promotion)*

- 3.46 There were three "demonstration towns" in this programme<sup>12</sup>. None, however, emerged through further research as being of particular interest as potential case studies.

### *Spearhead Authorities*

- 3.47 These areas had been identified entirely on the basis of their appearance in statistical records as evidence of particular deprivation in terms of health; and therefore inclusion indicated nothing particular about action to tackle health issues. Their number was also too great to be used in narrowing the search for potential case studies.

#### *Evidence Statement 10:*

*Among the initiatives aimed at better incorporating health issues into the activities of local authorities, relatively few referred explicitly to spatial planning. The WHO Healthy Cities programme was one initiative found to have spatial planning at its core, as a means of addressing determinants of health.*

<sup>12</sup> <http://www.dft.gov.uk/pgr/sustainable/demonstrationtowns/sustainabletraveldemonstrati5772>

## 4 Planners' Approach to Health

- 4.1 This chapter looks at the actors in decision-making in spatial planning, reporting on the awareness and knowledge of health that was found in the case studies, and on the factors which appeared to motivate their engagement with health issues. This covers not only those working formally in spatial planning, but also in transport planning, regeneration, and similar areas.

### Awareness of Health Issues among Planners

- 4.2 Among local authority officers, there was an almost universal awareness that importance should be attached to health, such that there often appeared to be a degree of surprise that anyone should be asking questions about this. There was clear evidence that planners believe sustainable development to include health and well-being, and they consider that their pursuit of sustainability encompasses the achievement of health outcomes. Participants in the workshops stated that the new sustainable development agenda had been particularly positive in encouraging spatial planners to think about health.
- 4.3 This extended beyond a concern for the provision of health facilities as part of the infrastructure, being expressed in terms of the promotion of health and wellbeing and/or concern to address health inequalities. A reference was frequently made to the imperative of seeking through spatial planning to create and maintain sustainable communities, and to the fact that health is one of the factors contributing to sustainability.
- 4.4 This appears to reflect a high degree of success in imbuing staff with a sense of corporate values, vision and objectives, among which some reference to health is normally found. A good example of this was a council whose staff all carry security passes with the five corporate aims on them, including "*a safer and healthier borough*": not just a gimmick, but apparently a live representation of values to which officers made immediate reference in conversation. This subject is also discussed more fully in §7.4.
- 4.5 When asked, many local authority officers explained that the importance being attached to health simply reflected the priority now set out in the respective authority's sustainable community strategy (SCS). In one area, the planners admitted that it was not long ago that they had held views along the lines of "health is about facilities", or that "health is about sanitation". Others were able to look back beyond the SCS and identified the origin of priority being attached to health in the *Local Government Act* of 2000 (see §2.69).

- 4.6 Others identified the awareness of health growing substantially after the 2002 *Local Government Act*. In the following years, it appears to have been quite normal for local authorities to identify improvements in personal health and in health care and a reduction of health inequalities as critical elements in the wellbeing or quality of life of their local communities. As one council officer observed, *“our members had been hearing from constituents about health problems for years, but they had never known what they could do about them”*; now the opportunity had arisen, which meant that they could be seen to be doing something.
- 4.7 Variations on the health objectives for sustainable development (see PPS1 in §2.34) appeared in the core strategies being produced by planners in their local development frameworks, and the concepts and terminology often seemed to be embedded in the culture and consciousness of planners interviewed. However, a clear message articulated by practitioners in more than one study area was that national planning policy needs to articulate more clearly where and how health benefits can accrue from planning decisions, and make clear what those benefits are. Nonetheless, this concern for guidance did not appear necessarily to translate into an understanding of precisely how it might influence their actions and decisions. Equally - and perhaps related to this - there was no evidence that a greater emphasis given to health outcomes in planning guidance would automatically imply that health would be given greater priority than currently.
- 4.8 This importance being attached to health by spatial planners was interpreted as being of immediate significance in the studies. Irrespective of how deep the knowledge and understanding of health issues might be (see the next section), *“constantly having health on the radar”* - as it was described by one planning officer - was found to be widespread. This would seem to offer a favourable foundation on which to build decision-making processes that could effectively address health outcomes, at least in so far as the areas of the case studies might be seen as typical.

## Knowledge of Health among Planners

- 4.9 If awareness of an importance being attached locally to health may be effectively universal, the next question had to be to what extent there was knowledge of health to back this up in terms of enabling effective action. The answer to this question varied considerably among the areas studied. There was certainly evidence that, with respect to health, planning officers may know the right words but are still trying to work out what they mean; and if they look at planning guidance, they do not find answers to these questions.

- 4.10 There was evidence that planners believe their knowledge of health issues is increasing, and could even be viewed as an expected part of the skill set of planners; however, the extent to which this knowledge fully appreciates the wider determinants of health did appear to vary considerably. Even where there was a relatively clear understanding of the important determinants of health, relating specific spatial planning policies to particular health outcomes was universally considered to be very difficult. Moreover, planners differed in the extent to which they considered an improved evidence base would help them. Whilst better evidence relating to health outcomes may be generally welcomed, there was some concern over the extent to which the planning system would have the capacity to deal with additional evidence - i.e. concern whether the resources would be available to take on any more information.
- 4.11 Most planners revealed no particular interest in ensuring that they kept up to date with the wider health agenda - not because of lack of interest, but, as voiced by some, because they felt rather swamped with the mass of "planning" guidance which they already have to absorb and apply. Among those who did recognise the need to keep up-to-date on policies in relation to health, some saw this as a challenge. Some felt that they could rely on updates from a specialist capacity in the planning department or as a separate facility elsewhere in the local authority (see §6.25), while others had no place reliance on external bodies. What reportedly worked well was having an individual charged with a general responsibility for advising the rest of the planning team when developments in another sector such as health have a potential impact - e.g. the head of Strategic Planning in Tower Hamlets Borough Council.
- 4.12 For planners dependent on external bodies, some looked to sources of information such as the RTPi or, in London, the GLA. Elsewhere, evidence suggested a vaguer expectation that relevant information should flow through planning guidance or via contact with the PCT. In turn, PCTs seemed to vary considerably in the extent to which they themselves recognised a role in proactively making available information to their partners. A positive example was found of a PCT inviting senior planners to seminars on new health initiatives.
- 4.13 Some regret was expressed that there was no single place from which planners could obtain information on health and how it could be influenced by planning decisions. Normally, they would refer to a PPS or Circular; but none offers what they need in this respect.
- 4.14 The history of joint working between PCT and council in one urban authority had brought the health professionals concerned to a point where they could offer constructive criticism:
- There were concerns about how national health policy issues - Health & Well Being and Health Inequalities - were captured or set out in national planning guidance -



*“formal planning guidance has historically passed health people by”*. This was most marked in terms of doubtful understanding of the connectivity between planning decisions and health outcomes. As an example - guidance required minimum housing density targets to be met, yet this “squeezed” gardens and public open space, which might have a detrimental effect on physical and mental health.

- Locally, spatial planners were demonstrating an improvement in understanding of the potential health gain from its policy decisions, but there was still an outstanding task of embedding this into day-to-day planning activity.

- 4.15 While spatial planners appeared to be well acquainted with the principles of the national “health and wellbeing agenda” (see §2.47), there was little evidence of any having substantive knowledge of the content of DH or NICE guidance relating to this, and they demonstrated no indication of belief that this would be of relevance to them. Specifically, little evidence was found of knowledge that this agenda was seeking to extend a concern for health outcomes to cover all the policy areas that could impact on the determinants of health. This might be seen as ironic, given the widespread knowledge among planners that their decisions were able to influence the determinants of health - an obvious area of policy overlap which could be used for potential cooperation, but only if recognised. Few planners knew of the intended role of the JSNA in this respect, and many appeared unaware of the contents of the local document.
- 4.16 On a technical level, there was evidence that planning officers may turn to published standards to help decide on health elements in their plans, e.g. the area of open space per head of population, e.g. standards from the Sports Council.

### *Transport Planning*

- 4.17 Emerging from discussions in a number of the studies - and one of the workshop discussions - was evidence that PCTs find it easier in practice to engage in transport planning than in the comprehensive spatial planning of the LDF. It was suggested that health professionals may more readily identify links with traffic planners because of the latter’s narrow focus compared to spatial planners attempting to embrace all sectors in their decisions. In contrast to this, however, one transport planner said problem was *“the rate at which new transport guidance is produced, which serves to produce an unmanageable list of ‘priorities’, [which is] almost meaningless”*.
- 4.18 At the same time, discussions at the workshops pointed to a degree of frustration being felt with transport planning. This related to the observation that transport planners conventionally based their plans on traffic forecasts that assumed the status quo in terms

of statistics on personal behaviour and choices. Consequently, transport planners were seen to be typically unwilling to plan for significant shifts in behaviour, e.g. making journeys on foot, cycle or bus rather than by car. They could therefore appear unwilling to consider a radical change of direction towards a very different future with a much greater use of walking, cycling and public transport than at present.

- 4.19 These comments were echoed by a spatial planner in one case study, who was disappointed with experience of trying to involve transport planners because they *"tend to see transport facilities as goods rather than as means to change people's behaviour"*. In another case study, far more pointed criticism was voiced of transport planning's real commitment to health. For example, it was stated that simply delaying the construction of a single major road by one year could release sufficient capital to transform the cycle network in the authority's area.
- 4.20 According to one health professional currently working with transport planners on the LTP3 (see §2.44), the guidance for this was proving far more effective in creating a fruitful basis for engagement by health. It was *"not exactly pushing at a fully open door - but much more open than previously, although we still don't see eye-to-eye on detailed policy"*.
- 4.21 Interviews with transport planners themselves did not provide evidence of a significantly greater knowledge and understanding of health issues than among the planning departments' staff. They did, however, provide evidence of a more active identification and engagement with measures aimed at health outcomes. They appeared to find public health benefits and disbenefits easy to incorporate into decisions, for example on whether and how cycleways and footpath networks were to be provided - certainly when compared with the spatial planners' perception of the complexity of their tasks. The interviews also revealed some frustration in attempts to promote health: an example was given of media attention given to a few cycling casualties and the dangers of roads for cyclists, whereas the media never focus on the health problems being addressed through cycling.
- 4.22 Critical voices were also heard from transport planners regarding the true importance of health in their activities: for example, the priority being given locally to achieving a modal shift from car use to cycling, walking and public transport had nothing to do with health, but was aimed at avoiding the anticipated congestion that would then undermine the area's economic growth.
- 4.23 One transport planner stated that *"transport planning is different .... LTPs are about trying to achieve behavioural change ... you can't build your way out of congestion!"* - although no evidence was provided that other forms of spatial planning were any less about behavioural change. A planning officer offered the observation that *"planning has to be 'subversive' to encourage healthier lifestyles"*, since it could only achieve this outcome

through measures which hoped to influence behaviour in the shape of healthier choices of lifestyle - essentially a parallel to the task for transport planners.

- 4.24 It should be noted, however, that the Strategic Health Authority is a statutory consultee on major infrastructure projects such as roads, but the PCT is not. Workshop participants believed that an opportunity for engagement had been missed here, in PCTs not being statutory consultees for planning authorities in LDF preparation. PCTs might therefore need to identify such planning issues in advance in order to become involved. In practice, PCTs were often consulted on such projects, but this was very much at the discretion of the planners.

***Evidence Statement 11:***

*A widespread awareness was found among planners that they should be pursuing health outcomes in their activities. This appears to derive from a degree of importance and prioritisation being attributed to health within the local authorities for which they work, typically manifest in the local sustainable community strategy. Further reinforcement appears to come from a relatively vague notion that national planning guidance presents health as part of sustainability.*

***Evidence Statement 12:***

*Spatial planners' policies to address health outcomes appear to have but a weak foundation in specific knowledge and understanding of how they can influence the determinants of health. Many spatial planners would welcome better information and guidance on how to address health outcomes, and particularly if this were embodied within formal national policy guidance. This was less the case for transport planners, who appeared much more comfortable and confident that guidance provided a sound basis for taking health fully into account in their decisions. There was little evidence of planners being either aware of guidance from NICE and the DH, nor any belief that this would be of relevance to them.*

## Motivation

- 4.25 If future guidance to planners is to bring about real change in how they handle health in their decisions, it was important to identify the drivers which might motivate planners in this direction. Repeatedly in the case studies attention was drawn by planners to the central role of policy guidance from CLG in providing the motivation for any new development in planning practice. This has been mentioned above in the context of practitioners'

knowledge and understanding of health. However, the overwhelming message which emerged is that, if a particular requirement were to be set out in new guidance with respect to health outcomes, there would be almost immediate and universal action within all planning departments to begin the process of fulfilling this requirement.

- 4.26 In the absence of national guidance as this form of driver, the case studies explored what motivation there had in fact been for the inclusion of health in spatial planning. This exploration began with the factors to which planning guidance does draw attention.

### *Expectations on Local Spatial Planning imposed by Regional Strategies*

- 4.27 LDFs had needed to comply with the policies of the respective RSS. In the review of RSSs (§3.2), a mixed picture emerged of acknowledgement of health as an issue, with only a patchy translation of this into policies. In particular, there was a widespread lack of clarity regarding guidance and expectations on how health outcomes should be approached in the LDFs. Despite - or perhaps because of - this, the evidence emerging from local planners suggested that RSS policies actually played very little role in whether and how health had been addressed in local spatial planning. The reasons for this were varied.
- 4.28 In one case, the core strategy had been essentially completed before the relevant RSS was finalised, which meant that it was the existing structure plan that had provided the strategic policy context - and this had provided no specific guidance on health. In another, guidance was taken from work on the draft RSS while it was still in preparation; but this again had provided no substantial guidance to how health should be handled at local level. In contrast, Manchester does have a significant focus on health outcomes in its emerging core strategy; yet it was explained that this was entirely due to the local agenda set in its sustainable community strategy, and that the latter would dictate the health focus, effectively regardless of policies in the RSS.
- 4.29 It would be wrong, however, to conclude from this that a regional spatial strategy is irrelevant in setting the agenda for local spatial planning for health. There was one regional strategy - the London Plan - which had set a clear agenda for health (see §3.16); and in the two case studies in London there was clear evidence of attention being paid to health in the core strategies - one in place, one in preparation - at least partly because of the expectations from the regional strategy. Nonetheless, there was a very clear indication in several case study areas that the local health agenda would almost certainly have been in place even without expectations imposed by a RSS.

### *Expectations imposed by the Local Sustainable Community Strategy*

- 4.30 In contrast, to RSSs, reference was usually made to the SCS when planners explained the motivation for addressing health in LDFs. With their focus on sustainability, SCSs had typically identified health as an intrinsic element of this, and hence improvements in health equality and other health outcomes as one of a small number of priorities. In Somerset, for example, one of the six aims of the SCS was as shown below.

***Aim 6 'Being Healthy':***

*"People are healthy and everyone has the information and support to be able to make the best choices about their lifestyles. There is little difference between an individual's health and life expectancy from one community to another. There is a range of health services to meet differing needs, including those who find it difficult to connect with services. People requiring care or support have good information and help that is responsive to their needs and gives them greater choice, convenience and ownership."*

Somerset, a Landscape for the Future: Sustainable Community Strategy for Somerset, 2008-2026

- 4.31 In turn, these priorities in the SCS had been used to set the corporate agenda for all activities within the respective local authority. Hence, health outcomes had been included among objectives for statutory spatial planning, transport planning, regeneration, and so on; and a consciousness of health issues had spread among the authority's staff.
- 4.32 Tower Hamlets offered a good example of strong links between SCS and LDF. Health was one of four key themes in the SCS, whose vision included:
- improving health and reducing differences in peoples' health by promoting healthy lifestyles;
  - supporting mental health services to improve mental health; and
  - improving access to, and experience of, local health services.

The LDF picked up this priority attached to "A Healthy Community" in the SCS, stating that *"every strategic objective and spatial policy in the Core Strategy has been developed to ensure that each contributes to the important element of improving health and well being"* (core strategy §2.11). Despite this, subsequent comments from the PCT and HUDU had included that the LDF *"could be more explicit, with greater references to health conditions and health inequalities"*.

- 4.33 In reality, the SCS was generally recognised as a high-level document which was not explicit on details, and the corporate objectives and priorities established in it did not normally spell out detailed expectations regarding future improvements. Specifically, they

did not set out which outcomes will require intervention through spatial planning, nor in particular how planning was to pursue these. For example, when a county council's SCS expanded its "Being Healthy" aim into an agenda for policy areas, it focused the envisaged actions very much on services to individuals:

- *"Keeping skills within the community, seeing older people as a resource,*
- *Helping individuals manage their own health and wellbeing,*
- *Encouraging people to use the 'natural gym' of Somerset to foster improved health and sense of wellbeing."*

4.34 In the case studies, how much the SCS actually influenced planners seemed to vary between authorities. Some said it was the first place to look to decide on objectives for their emerging core strategy; while others pointed to its very broad nature, and said it had limited influence in practice on their thinking. In the workshops, there was concern expressed that, while SCSs usually set out a clear vision for health outcomes, policies to achieve these often appear only implicitly in spatial planning policies.

4.35 On a practical note, evidence was found that not all study areas actually had systems in place for checking that spatial planning documents actually conformed to all the expectations of the SCS with respect to health. This did not seem to apply in those authorities with a strong corporate ethos, and particularly not in those with a dedicated health resource for which monitoring conformity would be part of the job description. Elsewhere, however, it sometimes appeared possible for LDF documents in practice to be produced without addressing SCS priorities in any substantive way.

4.36 Finally, attention was also drawn to another limitation of the SCS as a source of guidance for LDFs. SCSs were updated on a much shorter timescale than were LDFs, which could lead to sequencing problems. This could lead, for example, to a new and revised SCS being created before the production of the core strategy were completed which had been based on the previous SCS.

**Evidence Statement 13:**

*Despite the requirement for LDFs to comply with RSS policies, local priorities and not RSS expectations appear to be the main driver in directing LDF policies towards health outcomes.*

**Evidence Statement 14:**

*Local sustainable community strategies (SCSs) normally exert a strong influence on the broad objectives and priorities to which local spatial plans are directed, and this has been one of the key reasons for health outcomes being picked up in LDFs. Nonetheless, the impact of SCS prioritisation for health appears to be limited when little guidance is provided regarding what role and outcomes are actually expected from spatial planning. There appears sometimes to be an even stronger disconnection between the SCS of a county and the spatial planning being undertaken by the lower-tier planning authorities. This is an issue which is only partially addressed through the latter's own SCSs, particularly if the main focus of the respective PCT's engagement in local strategic partnerships (LSPs) is at county level.*

## 5 Health Professionals' Approach to Spatial Planning

- 5.1 This chapter explores the evidence found in the case studies for how health professionals and bodies are approaching spatial planning. The focus is on how this occurs from within the structures of the respective PCTs, and therefore the examination begins with these structures.

### PCT Structures

- 5.2 On several occasions, individual practitioners - both planners and health professionals - complained that a fundamental problem for a PCT's engagement is that no individuals among its staff had liaison with spatial planning specifically in their job description. Their observation was that, if the structure of a PCT does not create posts with this responsibility in a job description, engagement will not happen. Evidence was found for at least one example of this.
- 5.3 Commentators appeared to accept that, as any other organisation, a PCT can be expected to organise its structure primarily around its core business. At the same time, however, they had expectations that it should be possible to find every PCT function or responsibility in someone's job description. In pursuing the case studies, considerable difficulties often arose establishing who would be responsible within a PCT for liaising with spatial planners; and planners themselves frequently claimed that they had experienced the same challenge. Clear evidence emerged that this element of liaison is often covered in PCTs through generic responsibilities being attributed to individuals, such as "partnership working" in general, or "liaison with the local authority". While engagement with spatial planning would in theory fall under such a designated responsibility, the health professional concerned may not recognise it as such - due to the limited knowledge of planning referred to below (see §5.6) - or the link may not be pursued because of limited resources.
- 5.4 One of the Joint Health Units (see §5.14) provided an interesting perspective on this issue. The very positive benefits of having a team of PCT staff effectively sitting within a City Council's structure did appear to have one particular implication for the rest of the PCT: it could organise and pursue its core business with no attention paid to spatial planning, since this is the JHU's responsibility. As a consequence, the rest of the PCT's staff might overlook the possible benefit of itself informing or consulting the JHU on spatial planning or other matters relating to the council. Evidence of one case was found where the PCT's facility planning staff had quite overlooked the potential benefit of having involved the city's planning department in support for some of its proposals, a possibility which only emerged



in the case study interview. The implication is that, through giving responsibility to the JHU for liaison with the council, the PCT had also effectively delegated the role of knowing when liaison would be beneficial. A further potential problem was identified within the PCT relating to their information from the council effectively coming via the JHU: this could easily mask the origin of the information, resulting in them having a poorly developed knowledge of the internal workings of the council.

- 5.5 The quality and strength of a PCT's links with spatial planning in two-tier authority structures were generally found to be significantly less than in the case of unitary authorities. Since the PCTs' view of their "partnership" role tended to be in terms of commissioning, their stronger orientation appeared to be towards county-level cooperation related to the county council's social services. In one case, direct PCT links to individual districts could be restricted to no more than attendance at LSP meetings, all authorities being handled by one member of staff. As but one of any district council's functions, spatial planning's significance within that arrangement was found to be extremely limited by the planners involved.

***Evidence Statement 15:***

*PCTs do not normally view engagement in spatial planning as core business. In organising their staffing structures around core business, some PCTs were found to have inadvertently created situations in which no member of staff recognised a responsibility for liaison with spatial planners. This was particularly marked where two-tier local government structures led to the PCT's focus lying in cooperation with the county council as social care authority, while spatial planning is a district function.*

## Health Professionals' Knowledge of the Spatial Planning Process

- 5.6 Identified through an initial approach to a PCT as the appropriate person to interview, one public health consultant responded as follows: *"I don't know why you would want to speak to me. .... Public health knows nothing about spatial planning. ... Public health professionals learn nothing about spatial planning in their education and training, and there's no particular reason why they would learn about it in their normal job."* While this was certainly not typical of all PCT staff encountered in the research, there were echoes of this in the general approach to spatial planning from PCTs as corporate bodies. In the event, the consultant proved to have far more than a layman's knowledge of the spatial planning system, as indeed planners do of the local health arrangements.

- 5.7 At the other extreme were a few PCT staff encountered during the case studies who did have extensive knowledge of planning. While these were commonly former environmental health officers, it was not exclusively the case. More significantly, there was evidence of a correlation between these individuals and the examples of good communication and joint working between the respective PCTs and planning teams.
- 5.8 Some health professionals who had been involved to significant degree directly in spatial planning processes recognised that they had picked up a better understanding of the spatial planning system through this. Most, however, acknowledge that there is still much to learn. In Tower Hamlets, what had proved to be very effective in building up health professionals' knowledge of planning is the arrangement for 6-weekly meetings held to share policy and information and discuss specific schemes. Nonetheless, the PCT and Council still felt the need to organise additional seminars on health and spatial planning for their respective teams and colleagues. In Somerset, a 1-day conference was organised by the PCT during the period of the case study for a similar purpose.
- 5.9 One of the concerns held by planners about health professionals is that the latter's knowledge tends not to extend to the "limitations of planning" (see §6.41), i.e. an understanding of what planning cannot achieve. One former environmental health officer working in a PCT's team confirmed that he himself often found the needed to explain this to his colleagues. The importance of this understanding was also picked up as an issue in the workshops.
- 5.10 The structure of PCTs was found to play a significant part in determining which staff would learn about different parts of the planning system. There was plenty of evidence that PCT staff responsible for facility planning, for example, were often strongly involved with development management staff in relation to their own proposals for development. This did not, however, necessitate knowledge of the LDF process. In one case, the person concerned had never heard of the LDF, nor realised that the planners were involved in more than development management. In a further example, the PCT staff actually had knowledge of neither LDF nor development management processes; since all their schemes were handled by commercial developers or professional development agents, effectively "protecting" them from exposure to planners.

### *Institutional Knowledge*

- 5.11 One of the characteristics of PCTs which emerged in most of the case studies was the high rates of (a) turnover in staff and (b) restructuring of functions and responsibilities. This issue emerged again in the workshops, identified in both PCTs and local authorities, and

viewed as making it difficult to maintain good communication and effective working relationships.

- 5.12 Evidence for this problem in PCTs arose most commonly in concerns expressed by planners; although PCT staff occasionally echoed these concerns in explaining their own personal lack of knowledge. Both turnover and restructuring were seen to lead to a dissipation of the knowledge of planning gained by particular individuals if they move to responsibilities which no longer include continuity of contact with planners. Although it might be expected that knowledge should be passed to the next individual with this responsibility, several cases demonstrated that this does not necessarily happen.
- 5.13 This “leakage” of knowledge might be counteracted by conscious interventions, e.g. through record keeping and communication designed to do this, and NHS Cambridgeshire appeared to have achieved this through sufficient continuity in the team responsible for engagement in planning.

***Evidence Statement 16:***

*An extremely varied knowledge of spatial planning was found among health professionals, even among individuals designated as responsible for liaison with the district authorities in their spatial planning function. The better working relationships between PCT and planning authority tended to be found where responsibility for this in the PCT involved someone with a good understanding of spatial planning.*

## Motivation for Health Involvement in Spatial Planning

- 5.14 The case studies provided insight into the extent to which PCT staff generally believed that their organisations were struggling with the inadequacy of available resources to deal with existing workloads. Although the study is unable to comment on the veracity of this belief, there was widespread evidence in comments by planners that it is common for health colleagues to experience difficulty in finding time for meetings and/or to fail to attend. If PCT staff perceive that they are under-resourced, it may be assumed that any activity not viewed as core business will probably not be pursued unless there is a clear anticipation of self-interest. Since engagement in spatial planning is not seen as core business, the only motivator for PCTs to engage is likely to be either a formal requirement or some form of self interest.

### *Formal Guidance*

- 5.15 As explained in Chapter 2, health professionals are not required by national guidance to engage in spatial planning. Moreover, as one contributor to the study remarked, “*there is no national guidance that explains to health professionals how to get involved - often the PCT will come across what is happening by accident*”. Not only does this act as a deterrent from activity for those who believe they are already stretched in dealing with tasks of higher priority, it also ensures there is little incentive to learn about spatial planning. Unsurprisingly, this can easily lead to PCT staff - individually and corporately - failing to see any real benefit in any link to planning.

### *Healthy Cities*

- 5.16 Two of the case studies were in areas accepted onto the WHO Healthy Cities programme (see §3.40). Precisely why membership on this programme was sought in the first place could not easily be established, since the origin predated the involvement of those interviewed. However, they suggested that it reflected a pre-existing awareness of public health problems which had not responded sufficiently to previous measures. The opportunity was then seized to use the programme to provide fresh impetus in addressing problems. This status did appear to have provided a significant driver for change, primarily in precipitating a top-down demand for everyone in the respective administration to be seen to be acting on this health agenda and to interact with other organisations on the same basis.
- 5.17 This drive to address health can, of course, take many forms; and it cannot automatically bring PCT and spatial planners together. Nonetheless, one of the key elements of delivering the programme is to infuse all public bodies with a perspective on how they can impact on health. More significantly, the programme calls for action to be directed to identifying and tackling all determinants of health. In both cases among the case studies, this seems to have brought health professionals - if not necessarily the PCT as a whole - into engagement with spatial planning processes.

### *Sustainable Community Strategies*

- 5.18 In researching the motivation for PCTs to engage in spatial planning, mention of sustainable community strategies was conspicuous by its general absence. Although involved through LSP membership in the development of SCSs, PCTs appeared to pay far more attention to the LAAs through which they were to be implemented. This was consistent with the comment from some planners that PCTs as corporate organisations

were highly focussed on short-term performance indicators - largely output, as used for measuring LAA delivery - rather than on the “big-picture” outcomes to which SCSs are addressed. This could be contrasted with the far more central importance of the SCS for planners, in setting the strategic agenda for the LDFs. While planners sometimes showed strong evidence of being driven by the SCS agenda, as one health professional put it, “*the SCS has not been a key driver for the engagement between the health and planning professions outside the LSP.*”

- 5.19 PCTs are always formal members of LSPs, although evidence was found that the nature and level of their engagement varies considerably. When questioned, local authority staff tended to express the view that, while contributions from PCT representatives may have been of considerable value in the formulation of an SCS, these contributions were not the reason for inclusion of health among the local priorities. They believed that local residents and their elected representatives did not normally need prompting to attribute importance to health as a crucial element of their quality of life and the sustainability of their community.
- 5.20 The high-level status of SCS priorities (see §4.33 above) implies that there is little detailed target-setting or planning of actions included among its provisions. Implementation therefore implies subordinate strategies and plans translating the SCS priorities into plans of action. As a member of the LSP responsible for an area’s SCS, a PCT might be expected also to take some responsibility in implementation, exercising appropriate roles if necessary. There was widespread evidence for PCTs recognising responsibility for implementation of a SCS through the related LAA. In contrast, there was much less evidence of acceptance of such a role with respect to the LDF also being a means of implementing the SCS.
- 5.21 In the case of Tower Hamlets PCT, clear evidence was found that it had taken this view in its direct engagement, which appeared to be an on-going feature of spatial planning in the Borough. It was reported that the PCT believed its delivery of LAA targets for health improvement could be considerably enhanced by complementary interventions through spatial planning.
- 5.22 Elsewhere, there was less evidence that LSP involvement was being translated by PCTs into responsibility to engage directly in spatial planning. One reason for this was seen to relate to the “delivery” structures created under an LSP for the implementation of the SCS. In one area, for example, five thematic partnerships had been created in a structure under the main LSP, each corresponding to a priority theme of the SCS. Health matters were to be handled by a Health and Wellbeing Partnership Board; and they were not expected to be brought before the Sustainable Neighbourhoods Partnership Board, which dealt with

planning and regeneration. Each Board, supported by designated officers, set its own work programme within its remit of responsibility; and hence even cross-cutting issues were each the responsibility of just one of the 5 sub-boards. Moreover, as one support officer explained, there was no formal relationship or channel below the full LSP Board through which two thematic boards could practicably cooperate.

- 5.23 In one of the second-tier authority areas, the Health and Wellbeing Board set up under the main LSP had ceased to operate not long after the SCS had been adopted. However, this Board had been resurrected a few months before the case study once it was recognised that a valid role in supervising the implementation of the SCS did indeed exist. So far, the PCT contribution to the Board had been largely one of its representative listening and reporting back. Nonetheless, staff in the local authority hoped that this would provide a means of reinvigorating the limited engagement of the PCT.

### *JSNA*

- 5.24 It was noted earlier (§4.15) that JSNAs are often conducted without any explicit reference to spatial planning. This issue was picked up in the workshops, with participants acknowledging that initial guidance on JSNAs had not linked them to spatial planning, which may have been why opportunities had been missed. A participant explained that, in one borough, preparing the JSNA had indeed been a joint process between the local authority and PCT; but the input had been primarily from housing rather than from planning.
- 5.25 However, if a potential role for spatial planning were identified in preparing a JSNA with respect to the determinants of health, and the needs arising, it would presumably be incumbent on the PCT to consider how it should be engaging with planners to utilise this potential. Evidence for this was found in Tower Hamlets, where the JSNA recognises, particularly in relation to tackling obesity, that “*using planning to promote walking and cycling and control of fast food*” would be beneficial (p.44). The resulting involvement of Tower Hamlets PCT with local planners has been illustrated elsewhere in this report, including the use of planning powers to control fast-food outlets.
- 5.26 Some PCTs have found planning departments ‘reluctant to share [information] until ready’.

### *Corporate Self-Interest*

- 5.27 Evidence was found in the case studies for PCTs looking beyond formal requirements to identify a wider corporate self-interest in engagement with spatial planning. A clear articulation of this was provided on behalf of one PCT, whose decision to become more

proactively engaged with the planning system was described as having arisen from a number of challenges identified in terms of the PCT's own responsibilities:

- Strategically, the PCT felt its voice was limited within the LSP, and within the wider strategic activity in the area. For example, it was not able effectively to influence the activity of a regeneration body operating in its area.
- Operationally, it had found it was having too little impact on development management decisions relating to particular schemes of importance.
- The PCT was also becoming increasingly aware that the wider agendas for Health and Well Being and Health Inequalities were not fully appreciated by planning colleagues, and that this was unlikely to change without direct engagement. The PCT had identified a number of areas where a positive contribution by them to wider strategic outcomes could be in these agendas; but it would require involvement in planning to realise this potential.
- The planning system - and in particular planning guidance - was simply not understood at the required skill level within the PCT, and therefore closer communication on practical issues would significantly benefit internal skills and understanding.

5.28 Another PCT made the case more succinctly. It viewed spatial planning as a key means of delivering public health improvements. Specifically, it recognised that the local SCS and LAA represented key opportunities to embed health issues into the local spatial planning agenda. Moreover, it viewed the coordinating function of the spatial planning process as potentially more effective in addressing issues of inequality and exclusion than would be separate action by health bodies themselves. Independently, several individual practitioners made the point that, once it is recognised that health can be subject to determinants from several different sectors at the same time, a vehicle is required which can address the need for cross-cutting actions, and spatial planning already exists as a prime candidate for doing this.

5.29 In Cambridgeshire the motivation for engagement had reportedly arisen some years ago during the early development of the new community of Cambourne. Here, a significant volume of new housing had been built without any associated shopping facilities or shared meeting space (e.g. cafes, pubs) which was planned for a later phase of the overall development; and this had demonstrated the pitfalls of poorly coordinated development. Various health issues in the new settlement (e.g. high suicide rates, high birth rates) were identified by a local GP, precipitating reviews by the PCT and local authority. In turn, these had motivated both the PCT and local authority to learn lessons for future such developments - of which there were now several planned for South Cambridgeshire. This

- had been a key in driving forward the agenda to improve consideration of health in major new housing areas; and a significant role in this had been played by Cambridgeshire Horizons, the delivery vehicle for the growth, which itself had recognised the importance of health outcomes for sustainability.
- 5.30 Far more prosaic factors can motivate PCTs to engage in planning, such as the initial impetus for Tower Hamlets PCT to get closely involved with planning (see also other reasons above §5.21). It was reported that high land values in the borough and the large scale of housing development had meant that financial contributions from developers realised through planning obligations could be invested to produce new health facilities - but only if the PCT worked together with the planners. This initial financial benefit from several years ago had reportedly led the PCT into the strong relationship with the borough's planners which exist today.
- 5.31 Motivation on the part of individual health professionals would also inevitably depend on them believing that something positive could be achieved, i.e. that they could influence planning decisions and that something positive might come out of this. Some evidence was found of a generally positive attitude to this among health professionals, where the issue was of influencing decisions on individual planning applications in the development management process. In contrast, the evidence of various comments suggested much more scepticism in relation to their ability to influence LDF policies: apparently reflecting both limited ability to influence them and also some doubt over the real benefit of doing so.
- 5.32 Most health professionals who had actually been fully engaged in planning processes tended to be positive about the potential of spatial planning in helping to produce positive health outcomes. As in the case of planners (see §7.20), this appeared to reflect a pragmatic belief that planning could help in the difficult challenge of gradually creating healthier communities and behaviour. There was certainly no evidence of any naïve view regarding the power of planning to exert strong controls and to force change. Moreover, while they saw the potential, they were clearly aware that this would not always be realised, realistically accepting that other factors would often hold sway. Through their Improving Health Partnership, the health professionals of NHS Cambridgeshire felt they could influence spatial planning, and cited examples where their engagement had led to the local planning authority requiring changes in design, or even rejecting planning applications.
- 5.33 In the case of health professionals with no experience and often little knowledge of spatial planning, motivation for engagement was correspondingly lower. There was strong evidence that, for most PCT staff, it is a struggle to keep on top of the core business, and that this is essentially commissioning. Even among public health teams, evidence



suggested that it was easy for their agenda to be set by corporate priorities and national policies or requirements, such that engagement in spatial planning would not enter into their work as a matter of course.

### *Leadership*

- 5.34 Self-interest may be necessary, but is unlikely to be sufficient motivation to achieve proper engagement in planning by a PCT. If, as suggested above, the “default” position of PCTs is a strong focus on core business which is not conducive to engagement with spatial planning, an obvious source of energy to change this could be leadership within the organisation.
- 5.35 This is certainly the case in Stoke, where the leadership of the PCT took a conscious decision to engage in spatial planning, and the Board and Executive team committed to this. The key people involved include the Head of Premises Development, Deputy Chief Executive, and the Directors of Public Health, Health Promotion, and Planning and Modernisation. The Chair of the Board is on the Board of the Regeneration Partnership. It is evident that, through this leadership, supported by various formal and informal mechanisms, the PCT has made a cultural commitment to improved partnership working with planning, and that this is now delivering a return. Despite this, PCT staff acknowledged that the commitment to cultural change had *“not yet become normalised into effective partnership working on an ‘everyday, everyway’ basis”*; and that the skills and experience within the PCT were still developing, albeit from a low base, and that knowledge of how planning and local government in general work was still maturing.
- 5.36 One comment made during the research was that leadership from local authority members may not be assumed, since they do not necessarily make the link between health and planning. Each LSP is a forum for councillors to meet PCT representatives, and for the latter to inform and influence politicians regarding health. However, spatial planning is reportedly not often raised as an issue at LSP meetings, and spatial planners rarely attend, and so the link between spatial planning and health may not be made for the politicians, and they would therefore not be motivated to provide leadership in this respect.

**Evidence Statement 17:**

*In the absence of national guidance requiring it, PCTs appear unlikely to engage actively in spatial planning, their default position being to focus their structure and resources on the core business of which spatial planning is not a part. On the other hand, when a reason for corporate self-interest pointed in this direction, PCTs were found to have been well able to organise themselves to facilitate engagement in spatial planning. Motivation for engagement is, however, not sufficient; for effective engagement by PCTs in spatial planning also appears to require local leadership and staff with knowledge of spatial planning and/or with planning liaison in their job description.*

## 6 Interaction between Health Professionals and Planners

- 6.1 Having looked at spatial planners and health professionals separately, this chapter now turns to the evidence gained from the case studies in how the two interact.

### *Local Government Structures*

- 6.2 In each case study, it was necessary to understand the relationships between planners and health professionals within the context of broader organisational arrangements. Most critical among these was the question of whether the respective local government structure was unitary or consisted of two tiers. Another important dimension to emerge was where local authorities looked over their boundaries for partnership with other authorities - something that could add a significant dimension to spatial planning in particular, but also to health.
- 6.3 There is already a well-established structure of cooperative decision-making bodies in place to cover the whole of Greater Manchester. Dominant among these is the Association of Greater Manchester Authorities (AGMA), which produced in 2009 a joint SCS, "*Prosperity for All*". Within the AGMA structure, responsibilities are held by various Commissions. One of these is the Health Commission, which works closely with the Association of Greater Manchester PCTs on the conurbation's health agenda, supported by a joint Greater Manchester Public Health Network. Created in 2004, partly to link into AGMA, this network brings a number of advantages, one of which is the greater ability to find skills across the 10 members - e.g. several with knowledge in spatial planning. Other commissions have responsibility for the production of the new GM Spatial Framework, GM Housing Strategy, and other documents which provide a conurbation perspective on spatial planning within the 10 local authority areas.
- 6.4 Although compliance with the GM-wide strategies and policies for the conurbation as a whole is not statutorily nor otherwise legally binding, the authorities do subjugate their own policies to AGMA's on a voluntary basis. Transport represents an exception to this picture. The AGMA transport commission has not yet been created, since statutory responsibility is held for the conurbation by the Greater Manchester Integrated Transport Authority (GMITA).

## Arrangements for Collaboration between Planners and Health Bodies

- 6.5 It was necessary to consider the arrangements for interaction from several perspectives.

### *Communication and Information Sharing*

- 6.6 On the most fundamental level, there was significant evidence of problems of communication, most frequently from planners. *"I wouldn't know who to pick the phone up to if I wanted to discuss a health-related issue"* paraphrases a complaint heard in various forms from many planners. It also echoed a common experience of the researchers when seeking the identity of contacts in PCTs.
- 6.7 In looking at what was actually happening where communication lines were open, it was often necessary to distinguish between formal and informal communications. Several practitioners expressed concern that formal arrangements for sharing information do not always work as well as they should, or as intended. Formalities could easily get in the way of good communication.
- 6.8 In one case study, for example, joint working on the JSNA was at chief executive level, rather than more effectively through middle management contact. A comment was made that, if all formal notifications land on the chief executive's desk - i.e. among a large number of other communications - they may not find their way to the correct destination, or to all those who need them, and/or arrive on time. In another, evidence was provided of critical information for spatial planning from the PCT's estates department being supplied too late in the planning process to be taken into account. This had been due to the fact that the document containing the PCT's response had to go through all internal committees first.
- 6.9 Planners in several areas expressed a clear preference for being able to use more informal means of communication. The formal consultation in LDF processes, for example, had been found to be rather restricting, and had tended to fall later in the process than would have been really helpful, given a need for health input in analysis and policy formulation.
- 6.10 Similarly, health input into development management was considered to be far more useful if provided during the pre-application stage of a proposed scheme, so that it could better inform discussions with developers.

*A major change in recent years in South Cambridgeshire had been the growing practice of earlier involvement of health bodies with the developer at the pre-application stage is being formalised through the Community Engagement Plan of the LDF. NHS Cambridgeshire had been informed for some time of all outline planning applications which come in - plus detailed applications if changes were deemed material - which provides a request or opportunity to inform the decision-making process.*

*The PCT had a core of three people who routinely engaged with planners, although they could call on additional staff to assist them. The PCT was considered by the planners to be committing considerable time to responding to consultation.*

### *Partnership*

- 6.11 Partnership can be viewed as a rather overworked term at present, and appears in the name of many bodies which have been encountered in the case studies. If partnership were generally viewed as implying a relatively high degree of symmetry in a relationship, the general relationship between PCT and local authority - and certainly with respect to spatial planning - would not necessarily be put into this category. This is an observation on the practice found - certainly not a value judgement - and it was rare for any negative comments to be made to draw attention to imbalance in the health/planning relationship.
- 6.12 The most evident example of imbalance was the relatively low level of input from spatial planners into PCT decisions on the latter's strategies and plans; and this was regardless of how strong the involvement might be in the other direction. Some exceptions to this were found in the study nonetheless, typically relating to transport or planning advice being needed by the PCT in relation to the location or design of new health infrastructure.
- 6.13 Evidence suggests that, in practice, spatial planning is only exceptionally a truly interactive process between planners and health professionals. Ultimately, health professionals are but one group from a series of consultees, and they are rarely active participants in plan preparation. Some formal partnerships were found which explicitly addressed the health-planning interface. For example, the Cambridge City and South Cambridgeshire Improving Health Partnership was set up in response to circumstances as described in §5.29 above, This is aimed at embedding health and well-being outcomes into the planning objectives for the major new settlements with which the two councils were jointly engaged. The partnership involves staff from NHS Cambridgeshire and planning and environmental health staff of the two councils.

*Stoke's Healthy Public Partnership is a recently established forum for key players from the Health and Well Being Partnership Board of the LSP, plus other key stakeholders.*

*Relatively informal, the Partnership allows different professionals to come together to discuss issues of mutual concern with regard to health, planning and the city's SCS. Membership from outside of the LSP includes Keele University, Staffordshire University Institute of Occupational Medicine, and Renew (the regeneration vehicle for North Staffordshire), together with public health and planning officers. Initially set up by health and planning it is now chaired by Staffordshire University.*

*The benefits to date include improved relationships, joint learning in planning issues, and an informal opportunity to meet colleagues. Governance structures are still being developed e.g. terms of reference, role, and lines of accountability. Members of the Partnership are positive about its activity and point to the improved working relations as a key outcome.*

### *Joint Working*

- 6.14 The strongest example found of participation between PCT and planning staff in one another's decision-making processes was in Tower Hamlets. Here, it was considered quite normal practice for staff from one to spend time working directly in the other's team on particular projects, such as the PCT's preparation of JSNA or capital programme, or the local authority's LDF documents and major development projects. This approach had become ever more effective over time through boosting practitioners' confidence in taking on the role of advocate for their colleagues. As an example, development managers were confident in prescribing which, where and when health facilities would be needed; while PCT staff were equally confident of justifying the planners' decisions, if ever taken to appeal, through reference to their capital programme commitments. Reportedly, developers had become relatively quiescent in accepting the level of financial contributions required from them within s106 agreements, confident that it would have been well founded, and hence that there would be little point in challenge.
- 6.15 In Bexley, both planners and PCT staff felt that their arrangements for PCT input into planning were now very effective - particularly on an informal basis - acknowledging in this that they had benefitted greatly from some direct intervention and encouragement by a member of staff from HUDU who had worked alongside them. Interestingly, participants from both sides added a further comment that it had been the LDF process which had brought people from health and planning together, rather than their formal roles in the LSP working on the SCS. In the reverse direction, however, input from planning into PCT strategies tended to happen only at senior level - e.g. between the chief executives - and was therefore not having the same impact.

- 6.16 In theory, joint working could potentially be extended to the amalgamation of both partners' processes and strategy. In one of the study areas where it appeared to be best developed, a health practitioner stated that, at present *"there are no plans at present to integrate health strategic planning with that of the local authority, but this is not off the agenda"*.
- 6.17 In a study area with one of the most comprehensive arrangements for joint working between health and planning, it was surprising to discover a degree of resentment among health staff concerning some details of these arrangements. For example, the PCT currently had no direct influence over (s106) negotiations on planning obligations, and this was perceived as undermining the local council's commitment to achieving long-term health benefits in favour of short-term, often financial, gains. There was sympathy for the council's need to consider these factors, but no understanding for the exclusion of a health input to the discussion. The PCT had actually not yet been given any formal role in development management decisions and could *"only comment and lobby"* where it had concerns. Fortunately, these problems have been recognised and moves were afoot to rectify the situation.

### *Dedicated Staff*

- 6.18 Despite the general finding above (§5.3) regarding PCT structures, a few examples were found of PCT staff being given specific responsibility for engagement in planning processes. In Stoke, for instance, specialist project managers had been dedicated to provide input into the development phase of new schemes, liaising directly in two respects with planners: (1) evaluation of opportunities, business case approval, service and capacity specifications, design and steering through the planning application; and (2) premises development - effectively from planning approval to scheme completion.
- 6.19 In the other direction, only one example was found of planning staff dedicated to working with the PCT: a public health specialist specifically employed in the South Cambridgeshire planning department for this purpose. This specialist has a joint post in the planning and environmental health departments, and works "virtually" with Cambridgeshire NHS one day each week on public health issues. The purpose is to embed environmental health within planning activities. The benefit of this post was reported to be that planning activities in the district were constantly scrutinised for their consideration of the wider determinants of health.
- 6.20 A general point was occasionally made that it would be highly unlikely that the limited resources available to a planning team would ever permit a dedicated post. The exceptional case of South Cambridgeshire could justify this given its several major developments within the Growth Area. Far more common would be a planning officer with

responsibility for health liaison as part of a broader portfolio. While examples found of this were generally not senior posts, in the case of Tower Hamlets it was the Head of Strategic Planning who was responsible for ensuring health coordination, and it was the Head of Planning Policy in Bexley.

### *Secondments*

- 6.21 In some areas, evidence was found for achieving a dedicated resource on a temporary basis. Among participants at the workshops, for example, were two health professionals employed temporarily by PCTs to provide a direct input into planning activities, located in their respective local authority planning departments.
- 6.22 On a very short-term basis, a senior public health officer from the Tower Hamlets PCT had co-written parts of the borough's Core Strategy, sitting alongside the planners drafting it. A public health consultant in Manchester's Joint Health Unit had contributed a section on Design for Health in the city's Supplementary Planning Guidance for design in new developments. In both cases, the intention was positively to influence development management on the ground. Similarly, the PCT in Somerset was about to second someone to join the county transport team for a few weeks to advise and assist in the preparation of the LTP3 document - this was an experimental approach to test a new way of getting health into the thinking behind the plan.

### *Joint Staff*

- 6.23 A step further is represented by joint appointments between PCT and local authority of permanent staff, with the aim of providing a bridge between the two organisations. As a first example, the Director of Public Health in Tower Hamlets was a joint appointment between PCT and Borough Council. However, the examples of these found in the case studies were posts not dedicated to spatial planning alone, but rather to link the PCT across the board into all relevant local authority activities. Indeed, some of them had initially had relatively little impact on planning.
- 6.24 Many of them appointments had initially been directly related to joint initiatives. In Somerset for example, the PCT and local authorities had jointly funded posts promoting active lifestyles for about 8 years, with the aim of working through the authority structures in a strategic and coordinating role to organise events such as organised walks. These officers, however, have not generally developed their roles in engagement with spatial planning; although in one authority the healthy lifestyle officer works next to the planning department and has consequently developed an awareness of the need for interaction.



- 6.25 Two examples were found in the case studies of a Joint Health Unit established by the respective PCT and city council: these were Manchester and Stoke - i.e. the two areas in the WHO healthy Cities Programme. The box below provides details of the Manchester example.

***Manchester Joint Health Unit***

*The JHU is a team of professional staff with public health and related skills. It is located within the Council's organisational structure, and in one of its main buildings.*

*It was set up in April 2002, initially in a specific initiative with a remit to address teenage pregnancy: a small unit to get the issues onto others' agendas. Other functions were then added incrementally because of the growing unit's skills and/or independence of other Council departments.*

*Originally funded through the local "joint finance" budget, the revenue funding of the JHU is now predominantly from the PCT. Council funding still comes in as contributions to programme budgets.*

*The crucial benefit of the JHU is that provides the City Council with a dedicated "internal" resource on (public) health which can be called upon to feed into any corporate or departmental processes. This means there is no need to rely on input from PCT staff with other responsibilities. In addition, the close link between the JHU and other PCT staff means that the latter can be readily brought in by the JHU on the few occasions when this might be appropriate - e.g. PCT estates staff advising on the details of regeneration schemes.*

*One of the initiatives currently being driven by the JHU is "Valuing Older People", in which ageing is seen as much wider than health, but with health and wellbeing as a common theme.*

- 6.26 The Stoke JHU contains the post of Local Strategic Partnership Co-ordinator (Health), which is located in a Council building, but is an established post in the PCT's Public Health Team. Both this postholder and one of the public health consultants in Manchester act as lead officer to the respective LSP board responsible for health and wellbeing.

***Evidence Statement 18:***

*The case studies revealed a very wide range of different arrangements for collaboration between PCTs and local authorities. Although some were specifically designed to facilitate health input into spatial planning, it was far more common that this was but one part of more broadly-based arrangements. No strong correlation was found between the type of arrangement adopted and success in integrating health into planning, and factors such as political priorities and the knowledge of individual practitioners' appear to be of at least equal importance. In particular cases the creation of a public health capability within a local authority's structure provides a ready health input into spatial planning, potentially avoiding reliance on resources being made available from within the PCT's structure.*

## Different Cultures?

- 6.27 Researchers were alerted through stakeholder interviews to the possibility of cultural differences between planners and health practitioners as the source of challenges if the two were to attempt to work together. Again in the workshops attention was drawn to the possibility of joint working being hindered by “cultural differences” and the lack of knowledge among spatial planners and health professionals of how the others operate. In the case studies, the evidence for any cultural difference was rather weak and sporadic, although there was certainly evidence to be found of misunderstandings and/or misperceptions between the two groups that could be perhaps mistaken for cultural differences.
- 6.28 In some areas, some concern was found among health practitioners that most planning staff still had only a short-term perspective on how planning decisions impact on health, and that work would still be necessary to develop among them a more strategic, longer-term perspective. While not exclusively directed to them, this concern seemed to have applied primarily to development management staff, expressed possibly by health practitioners who had relatively little contact with strategic planners. Development managers were seen in such cases as overly concerned with density and other more static elements of the schemes with which they dealt, and did not consider the wider picture. Some health staff asked *“do planners understand that if we put something in - capital, buildings, etc. - we get outcomes over the longer term, and that’s what’s important: longer-term benefits for communities, shown through improving health indicators?”*
- 6.29 Numerous contributors to the research referred to engagement between planners and health professionals as being *“a learning exercise”*. There was acknowledgement on both sides that the cultures are very different in both professions, and that this could be quite problematic when attempts were made at collaboration. One of the most obvious cultural issues was demonstrated by comments pointing to a concern among health professionals that they were *“not sure what planners wanted from them”*, and vice versa. For both parties, this position contrasted with their respective experience of dealing with other professionals with whom there has been a longer history of engagement.
- 6.30 An interesting perspective on this arose in the workshops, in the suggestion that, in practice, PCTs seemed more willing and able to engage with planners around specific issues (e.g. planning applications) than as part of a policy-making process. It was suggested that this might be due to health professionals’ uncertainty regarding what might happen in the longer term, and what its impact on PCT resources might be. At the same time, participants contrasted the benefits of PCT engagement at the policy-making stage, i.e. engaging with policy makers to inform better policies ‘upstream’ would mean less need

for PCTs to engage extensively on individual site applications. This was particularly significant because, while PCTs may feel more comfortable engaging with development control than with forward planning, engagement on big schemes could place significant pressure on their resources. A rather different perspective on this was provided in one case study, where the comment was made by a planner that PCT staff “*find it difficult to prioritise among things that are not tangible or not of immediate significance for their own core business or related to their performance measures*”.

- 6.31 Practitioners attributed value to having arrangements which brought health professionals and planners together at an operational level so that they could learn one another’s ways of working. Even if the main driver for this might have been a specific task such as producing a SCS, core strategy or anything else, any vehicle that then facilitated informal exchange on a range of issues could support the development of more effective communication and better ways of joint working.

*In Tower Hamlets there is a shared understanding of health and spatial planning knowledge and issues between PCT and local authority planning staff. This is the result of close joint working between staff on the ground, supported by formal mechanisms such as the 6-weekly meetings on policy and specific schemes. The regular meetings provide a forum for open discussion and good working relationships, with no formal terms of reference until those currently being drafted.*

*Involvement is now being widened out to include more colleagues in each organisation through proposed seminars on integrating health and planning.*

*Mutual learning has been through active dialogue and engagement rather than relying simply on guidance and trust; and confidence has been built up over several years.*

### *Language*

- 6.32 There were some pointers to language playing a role in cultural differences. For instance, one planner pointed to the relative ease with which senior figures from health and planning can interact at very high “strategic” levels, particularly as demonstrated within a LSP. Here, the joint discussion is about broad goals, priorities, targets, commitment and so on - i.e. using the “management speak” common to all sectors at that level.
- 6.33 In contrast, once the interaction moves down to the level of practical planning and implementation, the differences in language would then more easily appear. A regeneration team in one study area were reporting to area-based partnerships which included a PCT representative. However, the health input had been very poor due to (a) the level of understanding and (b) the high turnover among PCT representatives; and therefore the team had fallen back to seeking health input from their own specialist source, explaining that “*at least they are able to speak the same language*”.

- 6.34 Undoubtedly cultural differences manifest themselves in terms of professional acronyms and other jargon, in which case the only solution would be for the special vocabulary of the other specialism to be learned. Unfortunately, however, some evidence was found of cultural differences going much deeper than this into language, to the extent that the same words might have different meanings. As an illustration, confusion in an exchange about “spatial planning” with a PCT manager was clarified through recognition that different meanings were being understood by the term, which the manager had interpreted as referring to the planning of the use of space within health facilities.
- 6.35 Even the word “health” appeared to have different meanings, sometimes subtly so. While this variation did not necessarily correlate to differences between the planning and health professions, there was one particular dimension which revealed what could be seen as a philosophical difference. Health clinicians clearly focus on the health of an individual, and public health professionals rather on the health of communities of individuals. While strategic planners would see themselves also dealing with communities, what they mean is subtly different, and relates strongly to geographical areas. Consequently, “health inequalities” for planners would tend to relate to geographical variation; whereas the staff of a PCT would be addressing inequalities between social groups, regardless of whether these might find geographical expression.
- 6.36 The term “sustainability” may also cause confusion. In one authority’s corporate plans, for example, the thrust of the approach to “*creating a sustainable environment*” in its area was “*to remove ugly and unnecessary road signs and guard against unsightly, unpopular developments such as wind turbines*”.

### *Compromise*

- 6.37 The case studies sought to explore the reasons for difficulties arising in the interaction between health and planning professionals in relation to the latter’s decision making. One of the issues being explored reflected comments made in the interviews with stakeholders, namely the suggestion that health professionals found it difficult to accept that planning decisions were almost inevitably compromises between conflicting objectives and priorities. Although some support for this view was apparent among planners, only limited evidence in the form of concrete examples were actually found. As one planner described the phenomenon, “*health professionals want health issues put first when we’re considering scheme applications - unfortunately officers and members have to look at schemes in the round*”.
- 6.38 Similarly, a public health officer identified the difficulty that many health staff have in understanding the planners’ responsibility for balancing competing interests and making

compromises, adding pointedly that, even if this were understood, there might still be a perception that compromises were not “balanced”.

- 6.39 Development management officers readily acknowledged that, in seeking a balance between competing interests, they sometimes found themselves misunderstood by health professionals and others with relatively narrowly defined interests in proposed new developments. Representatives of PCTs could experience difficulty in understanding why the full achievement of desired health outcomes needed to be compromised, particularly when the SCS and LDF had promoted them. It may be necessary to compromise with the commercial interests of a developer to ensure that a development proceeds at all.
- 6.40 One example related to how major regeneration schemes could often displace large number of people. The respective PCT had expressed concerns about the long-term implications of displacement on the mental health of many people involved, and requested that this aspect should be actively considered as part of the planning process. When the schemes in question had proceeded, the PCT reportedly expressed the view that this meant their views had been ignored. However, on balance the evidence suggested more the case that other factors had been given greater weight in the planning decision.

### *The Limitations of Planning*

- 6.41 In terms of cultural differences, planners were far more likely to draw attention to problems that arise because of what one called the “limitations of planning”. This relates to what appears often to be a perception that planners have far more power to direct and control development than is actually the case. One health professional readily acknowledged that the health sector typically has unrealistic expectations of what can be achieved by planning, giving the example of fast food outlets, which many of his colleagues would like to see restricted or prevented near schools. While this misunderstanding is in no way limited to health professionals, there was frequent evidence of planners viewing this as a factor which could undermine their dealing with them.
- 6.42 As a problem, the overestimate of planners’ powers appeared to impact most frequently in relation to development management, and particularly where a PCT wished to prevent a development which would have a negative impact on health. This could often be directly related to the need for evidence and to questions of material consideration as discussed later in §7.37.
- 6.43 Some health staff suggested that planners themselves thought planning to be more limited than it actually was. It was suggested that planners may often demonstrate “*an unwillingness to take a risk*”, which reflects a desire for an easier life - i.e. avoiding friction

internally, or with developers and landowners, and avoiding appeals etc. This was seen to apply to both officers and members. Planners themselves tended to describe such an approach as “pragmatic” (see also §7.19), and an example offered related to an analysis of current underprovision with open space: implementation could not be through a systematic strategy for which there would be no funding, but rather through seizing opportunities when they arose where new public or private land was to be developed.

***Evidence Statement 19:***

*Where health professionals are engaging in spatial planning, the representatives of the two professions appear to be learning about one another’s cultures, and hence reducing the scope for misunderstanding and friction between one another. Nonetheless, there is still some way to go: some differences in language, culture and approach remain, and hence issues may yet arise.*

## Timescale Issues

- 6.44 Several references were made by interviewees and participants in the workshops to cultural differences relating to the time horizon to which planners and health professional normally work. In PCTs, the dominant culture was characterised as a “short-term-targets culture”, contrasting with the longer-term view of planners responsible for producing LDFs with 15-year time horizons.
- 6.45 While these perceptions could not be ignored, the evidence did tend to undermine any suggestion of a major cultural difference. The production of LDFs and other activities in forward planning frequently impose relatively short timescales on the work of planners; and processes in development management in particular can be extremely tight in terms of time. In contrast, public health professionals are well aware of the long timescales needed for most of the behavioural changes and other outcomes to which they are working; and PCT staff involved in planning for major investment in health facilities need to have very long time-horizons with respect to their business cases.
- 6.46 This issue may be summarised in a single comment received: “*Differences in operational timescales between local authorities and PCTs is not really an issue - once it is understood what the timescales are, you can work around them*”.
- 6.47 In short, there appeared to be more perception than substance to the notion that different timescales provided a cultural challenge for planners and health professionals to cooperate. Confirmation of this was provided in one case study where planners and PCT

staff both made the same complaint that, while they themselves took the longer view, the others “*only want immediate results*”.

**Evidence Statement 20:**

*Although several practitioners made reference to there being problems of cooperation between health and planning relating to their respective time horizons, little evidence was found to support this being a real issue.*

## 7 Matters for Consideration if Spatial Planning is to aim at Health Outcomes

- 7.1 This final chapter builds on the findings in the previous three, introducing a series of practical issues to be addressed if the pursuit of health outcomes is to be properly integrated into the spatial planning process.

### Placing Health Outcomes on the Spatial Planning Agenda

- 7.2 In Chapter 4, evidence was presented that planners are well aware of health as an issue, and display considerable sympathy to the inclusion of health outcomes as objectives for spatial planning. Nonetheless, there are indications of references to health in planning documents sometimes being tokenistic. This being the case, there is a question regarding what factors are important if spatial planning is genuinely to adopt health outcomes as real objectives whose achievement is as essential and real a part of implementation as the delivery of housing targets or the creation of employment and retail floorspace.
- 7.3 Timing was often identified as a critical factor. A typical comment from planners was that *“the statutory structure [of the planning system] doesn’t lend itself to giving space for health to be taken into account, ... and, [as a consequence,] “the best time for planners to get to grips with a health agenda is in the pre-statutory period”*.

#### *Prioritisation*

- 7.4 In the workshops, participants identified several things which would provide incentive for engagement of health professionals in spatial planning. One was government pressure through guidance or legislation, or political pressure from the local community to work together. None of the latter was found in the case studies. However, in order to get something onto the planning agenda, there was strong evidence to suggest the need for awareness of what local government members think is important.
- 7.5 It would be naïve to assume that a link between sustainable development and health is recognised by councils, is being actively promoted by them, and underpins their activities. This is irrespective of what might be stated as priorities in a SCS or other corporate documents. In one area, for example, practitioners clearly believed that councillors were not really engaged with the healthy lifestyle agenda, despite this being a key SCS objective. The lesson to be learned is the danger of tokenism when higher-order objectives



and priorities are set in a SCS, but the 'golden thread' through to spatial plan making and decisions on individual applications is 'broken'.

- 7.6 The regeneration agenda in one of the study areas had been driven for many years quite openly by the need to reverse economic decline. This had not prohibited the recognition of significant health problems, concentrated in the recognised areas of multiple deprivation. Moreover health was formally recognised as one of the few strategic priority areas. Nonetheless, the primacy of the priority attached to economic development had overwhelmed other strategic objectives such as health improvement. As a consequence, there has been frustration among planners and health professionals that, despite the attention officially paid to health, in fact it could be promoted only to the extent that this did not compromise the relatively single-minded pursuit of economic development. Revealingly, one planner explained that, regardless of the SCS, the planning team looked upon economic development as being simply a means to the end of a sustainable and high quality of life, and that health was just as important within that goal.
- 7.7 This changed, however, when an independent report drew attention to the role that health plays in economic development, in particular that the employment prospects of many in areas of deprivation could only be realised if their serious health needs could be addressed. Once the pursuit of health outcomes became part of the agenda for economic development, the situation for those promoting health measures was reportedly transformed, and the ostensible priority given to health became a reality. There is a clear lesson to be learned here in terms of the value of ensuring that real, not just professed, importance is attached to health on the political level.
- 7.8 Promoting healthy lifestyles may be claimed as a priority, but it may not be given particular priority corporately in competition with economic development and other issues with which members more readily identify. The case studies did, however, provide notable exceptions to this. The Tower Hamlets core strategy picks up the prioritisation in the SCS to state that:
- "The concept of sustainability is an extremely complicated one with many interwoven factors needing to be addressed to ensure a successful approach. As such, every strategic objective and spatial policy within the Core Strategy has been developed to ensure that each contributes to the important elements of improving health and well being and tackling climate change through interventions in the built environment"* (§2.11)
- 7.9 Even when council members do pursue health outcomes, they do not necessarily turn to spatial planning as a means of delivering them. A very recent meeting of the borough council's Health Scrutiny Committee in one of the study areas had debated a paper it had commissioned examining ways to integrate its operations and those of the PCT. Its aim was to *"promote a much stronger preventative agenda to tackle inequalities, ... [linking PCT*

activities with] *many local government services that can improve people's general health and wellbeing e.g. housing, environmental services, leisure and cultural services*".

Interestingly, however, planning was not mentioned as a key service with which to link.

### *A Corporate Approach - the Example of Stoke*

- 7.10 The study was not geared to the systematic search for examples of best practice. However, there is some value in presenting the arrangements in Stoke in some detail to illustrate the impact of how health has been adopted onto the political agenda in one of the study areas. A corporate approach has been developed by the Stoke Healthy Cities Team and adopted by City Council. The broad approach on different levels is set out in the box on the next page.
- 7.11 Vision Watch as the highest level in this approach is an integrated management tool being developed to embed health issues within any policy or service developments and processes within the Council's structure. However, it is not concerned with scheme appraisal. It works at strategic, operational and community levels, simultaneously with other public, private and voluntary sector agencies. It aims also to provide a framework for the development of locally specific tools to work with existing structures and processes. A Healthy Public Policy Advisory Group monitors progress.
- 7.12 In Health Impact Assessments, there has been recognition of a skills gap and the limit to internal capacity, followed by an assessment of whether a pilot programme would deliver benefits. The pilot HIAs were led by the Institute of Occupational Medicine - 4 had been completed and one was in progress during the case study. A key result to emerge is that formal HIAs can be costly and time consuming, and that a local simplified approach could be more effective. This led to the development of a *Healthy Proofing Masterplans' Guide* and *Healthy Cities Checklist*.
- 7.13 The *Guide to Healthy Proofing Masterplans* had recently been produced in co-operation with the Institute of Occupational Medicine. "*The aim of this guide is to describe in detail how to systematically review masterplan designs so that they incorporate public health and healthy urban planning best practice*". It is therefore primarily aimed at public health and planning professionals new to healthy urban planning and design. It can also be used by local community groups and voluntary sector agencies.

***Four Levels of Action on Health in Stoke***

*Level 1: Ensuring that health and health equity are embedded in all local policy (Vision Watch) via:*

- ❖ Review of current policy-making processes
- ❖ Obtain agreement across council departments to implement Vision Watch
- ❖ Develop an on-line tool to facilitate Vision Watch
- ❖ Pilot Vision Watch in revising the Sustainable Communities Strategy

*Level 2: Mainstreaming Health Impact Assessments, including via:*

- ❖ Pilot a programme of HIAs in masterplans for selected areas of the city
- ❖ Provide training in HIAs
- ❖ Produce a Guide to Health Proof Masterplans

*Level 3: Healthy Urban Planning and Design, including via:*

- ❖ Produce a training package for Members, planners, and public bodies
- ❖ Produce a Healthy City Checklist
- ❖ Strengthen Sustainability Appraisal and Strategic Environmental Assessments
- ❖ Produce Healthy City Supplementary Planning Guidance
- ❖ Include health in Supplementary Planning Guidance on Urban Design

*Level 4: Community development to overcome environmental barriers to health, via:*

- ❖ Develop a community-led collaborative approach ('My Health Matters')
- ❖ Aim to reduce health inequalities related to healthy eating
- ❖ Focus on 3 areas of disadvantage

7.14 The Healthy City Checklist was developed by the Healthy Cities Team and the Joint Health Unit. Development managers use this to ensure that health issues are taken into account in their decisions. A comprehensive guidance note has also been produced to support staff completing the Checklist.

7.15 The new Health Supplementary Planning Guidance being developed will include provision to ensure the Healthy City Checklist is mandatory in development management. This is being developed jointly by the PCT and planning department, with input from the Institute of Occupational Medicine, and should be adopted by November 2010.

***Evidence Statement 21:***

*Unless there is real political prioritisation of health outcomes among members, a council's approach to health in spatial planning is likely to be little more than tokenism. This is irrespective of apparent prioritisation in a SCS. Conversely, if there is real political backing for the pursuit of health outcomes, it is possible to initiate a comprehensive corporate approach to the pursuit of health that should automatically incorporate spatial planning as an intrinsic element.*

## The Evidence Base for Decisions in Strategic Planning

- 7.16 A key feature of local spatial planning is the potential to be overwhelmed by the volume of information generated when planners seek to compose their evidence in preparation for a core strategy or any other document comprehensively covering all material sectors of life, of which health is but one. Planners pointed to this, not necessarily in search of sympathy, but to elicit understanding of how difficult it was to organise the evidence to support meaningful decision processes.
- 7.17 Faced with this mass of information, they readily acknowledged that it is much easier to deal with policy decisions relating to “hard data” such as the number of new dwellings, and less easy to handle evidence for “softer” outcomes such as sustainability, health and wellbeing. There was some sympathy for this view expressed by participants at the workshops, for whom it was self-evident that impacts on health - and particularly on ‘wellbeing’ - were difficult to identify and measure. They believed that developing an evidence base to illustrate the effects of specific initiatives or policies on health could be difficult and take a long time, and stressed that proving cause and effect would always be challenging. They felt that using limited resources in gathering such evidence would often be unjustifiable in terms of the result, and could actually distract attention from tackling important issues.

### *Health and Wellbeing*

- 7.18 Contributions from local authority planners revealed a generally ambivalent attitude on the subject of the evidence for policies promoting health in their LDFs. This can be contrasted with the more focussed concerns of their colleagues in development management (see §7.36). While the strategic planners acknowledged the general expectation of their policies

- being evidence-based, they all seemed to be well aware that there were strong limitations in this area.
- 7.19 They pointed to the well-established evidence for the health benefits of walking, cycling and other physical activities; and they were often aware of the role of open space and safe environments for mental health. At the same time, however, it was readily acknowledged that there was little evidence for the efficacy of their actual policies in producing positive health outcomes. A planner in one urban authority explained that any new open space created in areas of deprivation was unlikely to be used by many who it was intended to help, due to their fear for personal security; and the space would probably soon be taken over by the local drug culture.
- 7.20 Planners' approaches to this appeared quite pragmatic: they were aiming to create a framework within which others could promote healthy behaviour, and individuals could make healthy choices in terms of their own behaviour; but they realised that their policies could not determine the outcomes. As one planner commented: "*planning cannot make health improvements happen, but it can take away obstacles, and enable things to happen*". Another offered: "*the alternative of not having policies to promote healthy behaviour could only be seen as worse*".
- 7.21 While it would be unjustified to criticise the logic of this attitude, it did raise questions about implementation: if spatial planning policies could achieve health outcomes only in concert with action from other actors, were measures in place to ensure that such action occurred?
- 7.22 One answer to this question was for planners to take direct action in this respect. In one area, transport planners commissioned research to understand what motivates people in their transport behaviour (in terms of healthy lifestyle), and to understand "market segmentation" - i.e. which groups were most likely to take up healthier lifestyles with better promotion/information, and how to target them. The research informed a programme implemented by the county council in liaison with its district councils to promote healthier lifestyles and alternatives to car use.
- 7.23 In another area, a transport planner attempted to explain the different approaches to health of his profession and PCT staff. It was explained that even senior health professionals struggle with the language of transport planning. More importantly - it was explained - health professionals were most comfortable with concrete measures for identified "*patients*", but find it less easy to engage in decisions on policies aimed at "*abstract populations*". As evidence for this, an example was given of the local PCT promoting "led" walking events to promote walking as a contribution to health, to which participants were brought from far afield by car.

- 7.24 Planning at the most detailed level - housing layout, etc. - was more readily evidenced. In dealing with design guides, supplementary planning guidance, or development proposals, planners would turn to guidance from CABI or other publications for evidence of what works best in terms of health outcomes. In North Staffordshire, the Stoke-on-Trent City Council and PCT can call on the services of the local not-for-profit design consultancy of Urban Vision, based in Burslem School of Art.

### *Health Facilities*

- 7.25 There was a debate at the workshops about the extent to which PCT expenditure followed the demographic characteristics of populations throughout its area. Several comments suggested that commissioning by PCTs would normally follow policy priorities, rather than population characteristics, and funding would follow this. However, there was significant evidence that facility planning generally uses demographic forecasts as its basis; but the “choice” agenda had to a certain extent undermined the functional link between a particular facility and its intended or assumed catchment area. For these reasons, health planners now found that spatial plans for new residential development were of less value as a basis for forecasting demand for planning services or for corporate/financial strategy. One health professional expressed strong frustration that the PCT now found it extremely difficult to take planned development into account when planning its own facilities and services.
- 7.26 One participant at a workshop reported that, in London, there had been an intention to undertake a strategic identification of locations for health facilities, but this was not considered to have achieved much success to date. Yet a good example of demand forecasting for facilities was found in Tower Hamlets. There joint working between the Council and PCT involved the use of a *Planning for Population Change and Growth* model for assessing the location and type of health facilities. It uses GLA population projections at sub-borough which include changes arising from new housing developments - in contrast with the official ONS projections. It is a dynamic live model constantly updated by inputs from the borough and PCT, and reviewed quarterly. Outputs from the model were used by both organisations for the future planning of services and investment.
- 7.27 One example was found where the PCT had generated its own population forecasts, independent of the respective local authority, for purposes of planning for future facilities. Given that the local authority had a long-established competence in this area, and linked forecasts to spatial planning, this appeared to be both a waste of resources and a potential source for discontinuity and error.

### Health Inequalities

- 7.28 This is the area among health issues which is most easily evidenced for planning purposes. It was suggested in the workshops that some planning authorities had been moving towards more outcome-focused planning, for example that planners were starting to look at discrepancies in life expectancy between areas. There had been some indication of this in the review of LDFs, and in the case studies. However, there was little evidence of this providing any substantial basis for policies, other than as part of the overall deprivation that was used for targeting regeneration. One health professional explained that inequalities were being addressed through commissioning, rather than through health facilities, and therefore planning would have no real role.
- 7.29 Health indicators are already well established as part of the set used as the Index of Multiple Deprivation (IMD). In one local authority's LDF evidence base, for example, the only data specifically related to health were those in the IMD, using indicators of obesity and asthma for targeting walking, cycling, anti-pollution and open space initiatives as part of regeneration activity identified for a particular locality.

### JSNAs

- 7.30 Experience of JSNAs among spatial planners appeared to be extremely varied. At one extreme, examples were found of planners who had never heard of JSNAs.
- 7.31 Others were familiar with the local JSNA but very critical of those responsible for it. The view in these cases was typically that the JSNA represented "*an opportunity lost*": it could have been developed as a very useful database on needs related to health and wellbeing which could feed directly as evidence into spatial planning. The specific criticisms included the lack of analysis and interpretation in the JSNA, which left planners and others themselves to interrogate the raw data to find evidence for policies. Some - particularly in shire districts - found the JSNAs to have an inadequate geographical breakdown of data to inform their planning for particular localities. A common criticism was that the JSNA was entirely geared to the needs of PCT and social care commissioning and therefore "blind" to the potential use of information on health and wellbeing needs as evidence for other activities.
- 7.32 Several planners suggested that direct involvement of planners and other potential users in the scoping exercise for JSNAs would provide a relatively simple solution to the inadequacies which they detected. In the case of district planners, the point was made that the authority as a whole had effectively no real input to the JSNA process; and they did not

believe that PCT consultation through joint meetings with all the districts in their area had proven effective.

- 7.33 A more positive attitude towards JSNAs was found in unitary authorities, with some comments made regarding their usefulness in providing evidence for spatial planning. Some planners there stated that they found JSNA data useful in identifying areas for targeting action and investment. Having a coterminous boundary with the PCT helped considerably in this respect, building on the existing relationship with the authority's social care services in JSNA production. Tower Hamlets, for example, set up a joint group on data and intelligence involving planners to support JSNA production. Stoke has taken a similar path.

*In Stoke, partly to overcome historic issues, an inclusive approach between the PCT and planning authority was adopted (involving the Joint Health Unit - see §6.25) to establish a robust and credible evidence base.*

*The initial JSNA was acknowledged to be less than ideal and is currently being fundamentally rewritten to make it more robust and relevant for those seeking to use the information on needs.*

*Lessons learned from the development of a Joint Core Strategy with Newcastle-Under-Lyme Borough Council proved very helpful - having two quite different local planning authorities working on the same strategy had brought a dimension of particular significance to the process. In addition, some earlier consultancy work on locality-based data, jointly prepared for health and planning, also provided a useful input.*

*Currently, work is underway to produce a "Concordat on Evidence", particularly regarding commonality in the use of secondary datasets between health, planning and the local regeneration partnership. This will go to the Board of the LSP in November 2010.*

#### **Evidence Statement 22:**

*Planners are manifestly conscious of the expectation that their policies are based on sound evidence, particularly the need for them to stand up to challenge at a public enquiry or examination. Nonetheless, they appear to be quite content to pursue policies promoting health outcomes despite the lack of specific evidence that the policies in question will themselves lead to better health. They acknowledge that policies which lead to greater provision with open space, cycling routes and safe pedestrian routes will not automatically produce healthier behaviour among the target population. At the same time, they clearly recognise the evidence that more use of these facilities should improve health, and therefore trust that others' actions complementary to their policies can help the population to make healthy choices in their behaviour.*



***Evidence Statement 23:***

*JSNAs are generally not satisfying the needs of planners for data inputs to their processes, and they are not providing a solid foundation for joint working with PCTs. While some planners are disappointed by their lack of involvement in Joint Strategic Needs Assessments (JSNAs), others had never heard of them.*

## Decisions in Development Management

- 7.34 The overwhelming message from those responsible for development management was that health outcomes are but one of very many factors that need to be taken into account when dealing with any proposed development. Decisions on whether to approve a scheme, and what conditions or obligations should be imposed if approved, were always based upon compromise, seeking an appropriate balance between the various factors at play, and between different levels of priority attributed to these.
- 7.35 Planning officers were also acutely aware of the democratic dimension to planning decisions in this country. All key decisions are ultimately made within the political environment of decisions taken by council members, and therefore the recommendations which they put to members are inevitably sometimes designed to take into account anticipated views and concerns of the members. If health outcomes were high on a council's corporate priorities, this could be of considerable benefit in decisions which could influence health outcomes; unfortunately, the converse also applies. It is considered important to be realistic about the relative weight that healthy lifestyle issues or other aspects of health are likely to attract within the local political environment.

### *The Need for Evidence*

- 7.36 The second message from officers responsible for development management was that, of necessity, their decisions were very heavily influenced by the high risk of challenge through appeal. Whenever they recommended refusal of a planning application, or sought to impose conditions or obligations on the developer, they must acknowledge the latter's right to appeal. What this meant in practice is that the planning authority's decision would be challenged in terms of the evidence on which it had been based, and this must have been evidence that could be accepted as specific to the development site in question.

- 7.37 Evidence was only of any value in respect of a planning application if it related to something which was viewed as a “material consideration” when the decision was taken whether to approve.
- 7.38 The general subject of evidence for health outcomes was discussed in the previous section; and this may indeed come into play in dealing with appeals against refusal of permission to develop. The set of factors which would need to be taken into account at appeal is, however, much greater and more complicated. Those people who commented on this subject in the study stated that they would not feel comfortable refusing any application on the grounds of its effect on health, nor as a result of a failure to agree developer contributions for health purposes. Moreover, they had not heard of anyone having done so.

*In Stoke, an application for a fast food outlet close to a school had been refused on grounds that did not involve health, and went to appeal. However, in its appeal statement, the Council highlighted concerns regarding “healthy eating”. The Inspector refused the appeal but commented “I do not consider that planning policy has evolved to the point where ‘healthy eating’ is a material consideration in this appeal”. (This, however, can be contrasted with the later experience in Tower Hamlets - see §7.43.)*

*The view was reportedly then taken in the City Council that health issues currently did not carry any weight in planning terms, and hence that members could not refuse an application on health grounds. The Council therefore commissioned the production of the Supplementary Planning Guidance described in §7.15. Once adopted, this Healthy Urban Planning SPD would then become a material consideration in the determination of planning applications. This was seen as a “significant step forward” by both PCT and planning officers.*

- 7.39 Planners stated that the most basic piece of evidence for a development management decision was an ability to refer to an authority’s adopted development plan. A clear message emerged from discussions at the workshops that, in order to get funding through developer contributions, tackling health issues needs to be written explicitly into planning policy in the LDF, and this had not often been the case.
- 7.40 Where there was no core strategy adopted - e.g. for Manchester and the districts of Somerset - the relevant development plan was the Local Plan or Unitary Development Plan produced under the former statutory arrangements. Such plans would tend to be already several years old, and were therefore likely to have no specific policy aimed at health outcomes. Policies in any emerging DPD (especially the core strategy) might be referred to, depending on how far advanced it was in preparation. The absence of clear policies promoting health outcomes would very much weaken any attempt to seek such outcomes through development management decisions.

- 7.41 Even where a policy aimed at achieving health outcomes was in place, a persuasive case would still need to be made to demonstrate that it should be applied as intended to the specific subject of the appeal. One authority in the study had a relatively new policy which sought compensation for the impact of a development of >10 dwellings on the local infrastructure, including health services. When asked to provide costings as evidence for planning obligation, the PCT had only been able to do so on the basis of generic assumptions, and on several occasions had been unable to produce reasoned estimates specific to the proposed development in its specific location. As a consequence, a contribution for health services had been dropped from the contributions sought from the developer; and it is unlikely that the PCT would be approached again for this purpose.
- 7.42 A strong contrast to this example was offered in Tower Hamlets, where the PCT and local authority had a strong working relationship (see also §6.31).

*Due to the close working relationship between Tower Hamlets Borough Council and PCT, there is clarity on what the PCT wants in terms of new/improved health provision in any area. The PCT is able to respond to requests with clarity and justification due to the detailed capacity planning which has been undertaken. Its well-developed capital programme is annexed to the Health and Well Being Strategy, identifying future needs for the development of facilities, and coordinated with the authority's core strategy.*

*This means that there is a sound basis for calculating the impact of new residential developments on health facilities, to the extent that this can be done by the authority without needing input from the PCT, and the latter does not need to attend pre-application meetings. The PCT is comfortable in general that planners can apply this assessment to new schemes and is prepared to provide evidence in appeals, which gives the authority confidence in its dealings with developers.*

*The PCT is not a signatory to the s106 legal agreement if health contributions are negotiated and a Third Party Framework Agreement is being drawn up with the PCT. This means that the Council can set out the obligations to pay monies to the PCT received from developers, place obligations on the PCT to provide the facility/service etc. and to comply with standards and supply monitoring information. The Borough Council is hoping to roll these arrangements out to other organisations such as Transport for London.*

- 7.43 Another example of development management in Tower Hamlets had also had some recent publicity. This related to the Borough Council's intention of imposing more control on the concentration of fast-food outlets, particularly near schools, due to its impact on one of the Borough's key health challenges of childhood obesity. Using the "influence, incentivise, regulate" approach, this problem was being tackled by a number of departments and bodies, among which the planners had created a LDF policy against over concentrations of fast food outlets near schools. A recent High Court ruling had then established that this policy could be taken into account as a material consideration in development management decisions. At the same time, schools had introduced a healthy eating policy and were educating children on healthy foods; environmental health officers

played a part in regulating the retail premises; the PCT was encouraging healthy food through its Partnerships Healthy Borough programme; and healthy food offers were being promoted through new farmers' markets. Planning played a key role in coordinating this type of concerted action to solve major health problems in the borough, but recognised that its direct role was only one aspect.

### *Health Facilities*

- 7.44 The development management process should play a key role in the delivery of sustainable communities, particularly in major urban extensions, where new health facilities are both likely to be needed and should in theory be (part-)funded from developer contributions on an equitable basis.
- 7.45 Strong evidence was found that planning authorities were well attuned to the importance of infrastructure provision as part of sustainable development, and therefore health facilities were being given due importance along with roads, sewers, schools, and so on. As a general rule, proposals for new facilities would therefore be looked upon favourably, although of course subject to the same tests of suitability as any other proposal.
- 7.46 There was some criticism from planning officers of PCTs and health trusts regarding the health bodies' lack of concern for the wider objectives being pursued by spatial planning when these bodies were themselves planning the development of hospitals and other health facilities. Like all other developers, land ownership and finance were seen to play an understandable and key role in development plans for facilities. The criticism related to the degree to which these factors might be seen to be overriding other local concerns regarding accessibility, area regeneration, or similar. One case reported to the study team reflected concerns being ignored when raised by the planners regarding the unsustainability of the location for a hospital and its negative effect on health and wellbeing.

## **Funding**

- 7.47 Infrastructure Delivery Plans were also playing a role in facilities planning. Planners highlighted this as the place where the location, timing and funding of future health facilities would be identified, and indeed for the provision of cycleways, leisure facilities, green infrastructure, and other developments that would impact on health. Local authorities had long ago recognised that contributions from developers would never be sufficient to pay for everything on their 'wish list', and therefore were having to prioritise among potential

beneficiaries e.g. flood mitigation, sewerage, roads, public transport, affordable housing and other infrastructure, in addition to those relating to health.

- 7.48 There was evidence that some authorities did seek to give priority to health facilities. However, the example below was offered in one study of how difficult this might be in practice.

*A major extension to a former industrial village was being planned with the aim of facilitating the regeneration of the village centre. The new population was to be served by expansion of the latter, including the existing GP clinic. Although accepted by all parties, this idea is now in danger of failing. The current surgery is incapable of expansion and modernisation in situ. A potential site has been found, and in theory work should begin in the near future to ensure that the facility is ready as new people start to move into the new housing.*

*However, the GPs themselves cannot afford the significant up-front funding of the new development and the likely early-years shortfall of income until most of the growth has occurred. Equally, the developers concerned are unwilling to agree to contributions on the scale required until they have been able to generate sufficient profits from house sales (given that they have to front-fund land purchase, and the roads, sewers and other technical infrastructure). The planning authority is trying to work with the PCT on this, but with little success to date. The big fear is that, without a new surgery in place, newcomers will register elsewhere, thus undermining both the future of the local surgery and the sustainability of the future settlement.*

- 7.49 The HUDU model (§2.41) had been piloted in Tower Hamlets and continued to be used there. However, there had been some recent challenges from developers, and in two cases in 2007 the Planning Inspectorate raised concerns regarding: the model's policy backing; its handling of capacity and slack in the system in relation to new residential developments; the functional and geographical links to proposals; and the timing of revenue elements. The Inspector had ruled that a requirement for 100% of additional revenue costs did not comply with national policy guidance (Circular 5/05). Reportedly, the Council was now tending to use only that part of the model relating to capital costs for new health provision, except where they could make a special case for revenue contributions in addition.
- 7.50 In another case study, one health professional felt that the PCT had "*missed a lot of planning gain*" from the development management process. The claim was that the council "*are resisting any requests for planning gain from us - not directly, but just stonewalling*". Off the record, the interpretation was of a simple "*desire to avoid setting a precedent which would then be picked up by the Police and all other public bodies seeking to share in developer contributions*".

*Evidence Statement 24:*

*Planners generally believe that health outcomes have hardly ever been used as grounds for refusing planning permission, and that to seek to do so would probably result in failure. They also report problems encountered when seeking to use developer contributions for health facilities. These limitations on action reflect partly the difficulty of establishing robust evidence that links specific health outcomes to any particular development. They also follow from serious doubts whether health would be considered at appeal to be a material consideration in a planning decision. Related to this, there appears to be a common belief that, if national planning guidance were formally to establish health as a material consideration, this would both remove these doubts and also enable evidence of health impact to be handled on the basis of reasonable probability rather than absolute proof.*

## Regeneration

- 7.51 Although there was strong evidence of health being a recognised issue in regeneration areas, there was a less than uniform pattern of success in bringing health into planning for regeneration.
- 7.52 One area claiming some significant success was Manchester. Here, the framework for health outcomes was already 10-15 years old, following the early corporate recognition of the city's serious health problems. It was a holistic approach, aimed at the cross-cutting themes of sustainability and quality of life. However, one of the challenges experienced was that, the term "health" being so broad, partnership working with health professionals was much more effective when precision was achieved in determining specific health issues with which to deal. Otherwise, planners' approach to health was more about flagging up its general importance and identifying particular issues, rather than creating direct health initiatives. The key to successful practice on the ground was seen as partnership working - the regeneration team acting as enabler and facilitator, encouraging actions by the PCT and others.
- 7.53 Several different types of regeneration agency had been operating in different areas - established under New Deal for Communities, Housing Market Renewal, and as regeneration companies or partnerships. All with a degree of independence from the local authority, their focus had been very much on physical renewal - reclamation, demolition and renewal, and environmental improvement - as the primary means to achieve regeneration of the local economies and communities of their relatively small areas of operation. Perhaps understandably, they appeared to have paid little direct attention to

health issues, relying on the health sector to fit in to their plans under the overall coordination of the spatial planning of the whole local authority area. PCT staff reported having to “*knock hard on the door*” to get health issues considered by these vehicles, and only with limited success.

- 7.54 There were, however, cogent reasons offered why relatively little attention might be paid by regeneration bodies to health outcomes. While there might be a well-established link between health inequalities and social and economic inequalities, those involved in regeneration were also acutely aware of the likely result of their own actions. They acknowledged that the successful regeneration of an area would often precipitate the outward flow of the most deprived residents. This would merely relocate the health problems elsewhere to the extent that they were related to people and not directly attributable to the area’s physical characteristics.
- 7.55 Another factor which served to play down the role of health was the frequently encountered objective for regeneration areas of attracting into them those social groups who currently exercised their choice to live elsewhere. In one area focus groups and other research had provided a fairly consistent picture regarding the factors which needed to be addressed to attract wealthier, more active and entrepreneurial social groups into the areas being regenerated: education facilities, housing, security, and the physical environment. Employment and social or sports facilities might be mentioned; but apparently health did not appear. Health might be a major issue if aiming to improve conditions for the present residents - as officially in the New Deal for Communities - but it was of little importance in attracting newcomers.
- 7.56 In seeking to improve health in regeneration areas, planners reported that they could sometimes find themselves in conflict with strategic plans for new health facilities. It could be much easier and cheaper for health bodies to develop facilities on more spacious, greenfield sites peripheral to an urban area, with better general access, at least for car transport. Yet, in terms of both better serving the disadvantaged communities and contributing to physical regeneration, facilities within the urban cores would be much more beneficial and sustainable in spatial planning terms.

***Evidence Statement 25:***

*Although health inequalities are widely recognised as being strongly correlated with the social and economic inequalities manifest in regeneration areas, there is little evidence of health being given priority in regeneration. Health provision is not viewed as a determining factor in making regeneration areas more attractive; and there is always a fear that the people with health problems are likely to be displaced to other areas.*

## Housing

- 7.57 During the case studies, an exploration was made of the possibility of health being incorporated into the spatial planning being undertaken by local authorities' housing functions. Very little evidence was found of this. Despite this, as with planning and transport officers, there was a clear recognition of the importance of health in corporate priorities; and this importance was recognised through mention in housing strategies, albeit without evident policies targeting health outcomes in any substantial way.
- 7.58 Housing officers pointed to the importance of health in the origin of UK housing legislation in the 19<sup>th</sup> century, but also that the function had changed considerably since then:
- In terms of supply, the pressure on production was generally so great, and the availability of sites so small, that choosing between sites on the basis of health factors was effectively out of the question. Health may impact on decisions regarding layout, but that is more an issue for the planners.
  - In housing provision as a service to individual households, there were still strong links to health; and there was an element of joint assessment for households knocking on the housing department's door; but this bears little direct relationship to spatial planning.
  - The Government's Decent Homes initiative in the public sector may have had strong health effects; but it was not viewed as having been a driven for the policy; and it had applied to the whole stock without an intended spatial dimension.
  - Similarly, action on Decent Homes and general unfitness or overcrowding in the private sector might have been seen as having a health dimension. Yet this was driven essentially by national standards (of fitness, etc.), and again could not be viewed as spatial planning, except perhaps when tied in with area-based regeneration.

## Tools and Techniques

### *Health Impact Assessments (HIAs)*

- 7.59 The most commonly used formal tool for bringing health into spatial planning is the Health Impact Assessment (HIA - see §3.13). There was some concern expressed in one area regarding the quality of HIAs. It had been discovered that the consultants brought in to undertake the process had relied heavily on the local PCT for guidance on how to prepare



the document and obtain the data. Given the general benefits of joint working, the implication was clearly that PCTs' more direct involvement in, or responsibility for HIAs could bring wider benefits in their engagement in planning processes.

- 7.60 Although HIAs are required for major schemes they tend to be done as part of the application process alongside many other documents. The planners in Tower Hamlets always include health impacts when scoping the socio-economic part of the EIA process, which enables health to be considered earlier in the process. In South Cambridgeshire, the Development Control Policies DPD requires a Sustainability Appraisal and Health Impact Statement to be submitted with all planning applications for major developments of 20 or more dwellings (although in practice it had been recognised that this threshold was too low). In contrast, minimal use has been made of HIAs in Somerset so far, mainly undertaken to examine the business case for major highway schemes.
- 7.61 In Stoke, the new Healthy Urban Planning SPG (see §7.15) will introduce a threshold above which developers will be expected to produce a HIA - currently proposed for schemes of over 50 units. However, the development management team commented "*we needed something quick and dirty, as opposed to formal HIAs which can be lengthy, and sometimes unwieldy*". Consequently, a guide to "Health-Proofing Masterplans" is being formulated as a proactive attempt to introduce a "mini-HIA" approach to health assessments of smaller, less strategic sites, and to do this earlier in the development management process.

*'...doing a health-proofing review of masterplan designs is not a substitute for a Health Impact Assessment (HIA). HIAs are often commissioned late on in the masterplanning process once the final preferred masterplan design option has been developed. Health-proofing masterplan reviews are generally easier and quicker to do and, when undertaken on draft designs, can provide at least 50% of the benefits of doing a full rapid HIA at a later stage'*

*Source: Health-Proofing Masterplans - A Guide, p.11*

### **Supplementary Planning Documents**

- 7.62 Examples were found of these being used, as intended, to provide greater policy detail than could be found in a core strategy. Some were designed to promote health outcomes.
- 7.63 In Bexley, the 2008 SPD on planning obligations has an appendix on health contributions. It refers to policies in the then London plan (2008) on: the protection and enhancement of social infrastructure and community facilities; the improvement of the health of the local population and reduction of health inequalities: the requisition of HIAs for major

development proposals; and the need to have a clear framework for planning obligations. The PCT was involved in drawing up the SPD, and it has regular quarterly meetings with the planning department on progress on obligations and current negotiations.

- 7.64 A very interesting case was discovered in South Cambridgeshire, where efforts were reportedly being made to have the JSNA translated into a Supplementary Planning Document. The logic of this suggestion was strong: were this initiative to succeed, a requirement to address needs identified in the JSNA would become entrenched as a formal part of the planning system, and hence become a material consideration in all planning applications. It was explained that this reflected a perceived need to ensure the JSNA would be made better use of in spatial planning.

***Evidence Statement 26:***

*The use of HIAs is not universal, reflecting varying perceptions of whether the cost and time involved can be justified by the benefit. An example was found of “mini-HIAs” being developed - a simpler process requiring far less resource - which might offer a more beneficial approach.*

***Evidence Statement 27:***

*A growing interest was found in the local development of supplementary planning guidance within a LDF to entrench health issues more firmly into development management. This is seen as presenting an opportunity to provide much more detailed guidance than in a core strategy. Significantly, it is also recognised as presenting an opportunity to establish health as a material consideration in planning decisions, even without national guidance.*

## Monitoring Health Outcomes

- 7.65 It is a matter of good practice to monitor implementation as a means of ensuring that what was intended is actually happening. With respect to health, the importance of this was underlined by a comment emerging from the workshops: while it is commonly agreed that having planning policies aimed at health outcomes is good, how these policies will be implemented is often unclear.
- 7.66 Moreover, in the context of strategic planning, monitoring is a key learning exercise through which existing policies and practices can be reviewed and revisions considered for improving policies, plans and strategies. The planning system imposes an expectation on local authorities to monitor their strategies and plans, and there is a statutory requirement for core strategies to include a framework for monitoring policies. Where core strategies

have been judged as “sound” by the Planning Inspectorate, this would imply that this soundness extends to the monitoring framework.

- 7.67 The review of LDFs and RSSs had established that the formal monitoring frameworks being used - linked to Annual Monitoring Reports (AMRs) - were not measuring whether those policies aimed at health outcomes were having the desired effects. In fact, health appeared in these frameworks almost exclusively in the form of generic indicators such as obesity or mortality rates, with none capable of being used as a direct measure of successful policies. The indicators used tended to reflect the national set of indicators used in LAAs and in reviewing PCT performance. Since all LDFs had been judged as “sound”, this approach appears to have been acceptable to the Planning Inspectorate.
- 7.68 When asked about monitoring, all planners readily acknowledged that there was no effective monitoring of the health outcomes achieved through their policies. They stressed that this was not unique to health outcomes, being an issue wherever the strategic objectives being pursued would only emerge over the long term. In Manchester’s regeneration areas, for instance, health outputs were not directly measured, but rather picked up by health indicators reported to the area board; in this there was a conscious acknowledgement that no direct correlation could be expected within the framework of the 3-year delivery plan.
- 7.69 As also emerged from the workshops, they also pointed to the fact that spatial planning policies could not alone bring about health outcomes, but only in conjunction with others’ interventions. This pragmatic attitude was entirely in keeping with their acceptance of the lack of specific evidence discussed above (see §7.19): specifically, they did not view the difficulty of monitoring health outcomes in relation to planning policies as being in any way a reason not to promote the policies in the first place.
- 7.70 The reality for planners can be seen as directly analogous to the problems of collecting evidence for health policies:
- It would be generally difficult and resource-intensive to collect longitudinal data on health outcomes at appropriate geographical scales to monitor policy-led changes on the ground.
  - Even where data were available, there would normally be no realistic and reliable means of establishing causal links between policies and outcomes.

For these reasons, the planners appear to be quite comfortable with the lack of direct monitoring. However, when asked about the value and purpose of including generic indicators among published monitoring data, no cogent explanation was offered, other than

the imputed benefit of using data consistent with other monitoring exercises. No claim was made for the indicators providing useful information about policy implementation.

- 7.71 An interesting debate arose in connection with the promotion of cycling routes in the area of an urban authority. Fairly robust data were available to evidence the outputs of a general reversal of a long-term decline in cycle use in the area, following promotional campaigns and plan-led provision of new cycle routes, and also an actual increase in some areas. However, the actual increase in cycling appeared to be related more to the socio-economic status of areas, rather than to interventions; and there were no equivalent data on improvement in health. In other words, there was no evidence of positive health outcomes, nor for any causal links.
- 7.72 One critical issue is whether anyone is monitoring whether spatial planning policies are actually being implemented in terms of whether they are being appropriately and consistently being applied through the development management process. This might appear to some to be a superfluous question, given that forward planning and development management teams are normally in the same department, certainly from the same profession, within any authority. Nonetheless, there was significance in raising the issue. Moreover, similar concerns were raised in the workshops, where a potential disconnection between LDF policies and development management practice was perceived, for example where officers engaged in the latter were not focused on implementing the policy framework. Participants suggested that development management officers were not necessarily thinking about health issues on individual planning applications. Some referred to experience in consultation on applications where policy planners in the same authority and/or PCT staff had often been brought in too late, when the main features of development schemes had already been decided.
- 7.73 Staff from one planning strategy team responsible for the LDF stated simply that they did not know whether policies relating to health were being applied by their colleagues who were handling development management. Comments from others indicated that they did not always expect LDF policies for health outcomes to be applied, since development management operated on a case-by-case basis, and other issues would sometimes need to be given priority - this echoes the discussion of development management above (§7.35).
- 7.74 In Stoke, the Planning and Healthy Cities Team had recognised the limitation of their current monitoring framework and identified two 'themes' in terms of how they would improve things in the future. They planned to be quality-assuring the application of policy, creating systems to track that policy is applied as intended, using various tools and techniques. Interestingly, they also planned to be monitoring the returns on inputs in terms

of the health benefits over the longer term - i.e. a return on investment, “*what comes out from what goes in*”. Health indicators have now been included as part of Sustainability Appraisals in Stoke, resulting from a review by the Institute of Occupational Management. This has led to a list of health outcome indicators being jointly developed with the Healthy City Joint Unit to align Health City and planning activity by focussing on outcomes, and to develop a means to monitor and measure change over time regarding Health and Well Being and Health Inequalities agendas.

- 7.75 Even if the application of policies through development management is being monitored, a further question still remains regarding the quality of monitoring and enforcement of conditions applied when planning permission has been granted. Attention was drawn by some to the effect of limited resources within planning departments which meant that checks are not always made on the fulfilment of conditions. As explained above (§7.50), health does not necessarily enjoy much attention among the obligations imposed on developers; however, where health benefits are to be produced, it is essential that delivery is monitored.

***Evidence Statement 28:***

*There appears to be very little meaningful monitoring of spatial planning policies which are aimed at health outcomes: the implementation of policies is not always being monitored, nor the direct effect of the policies in terms of their impact on health in accordance with what was intended. Generally, only broad health indicators are being monitored - primarily those used for LAAs - and planners appear to be well aware that these cannot be linked directly to the effects of their policies.*

## Critical Factors for Success

- 7.76 One message emerging from the workshops provides a useful introduction to answering the question aimed at identifying critical success factors. This was the insight that planning policies to support health need to be understood by all as “building blocks” for future interventions which necessitate complementary action by others. In other words, all concerned should recognise that actions through spatial planning are necessary, but also that they are alone not sufficient to provide a solution. Planners therefore need to seek appropriate cooperation in designing policies, and then again in implementation. Equally, success in this will require support through policies and actions by PCTs and other local authority departments; but, for this, they too must recognise the role that spatial planning can play.

### *Common Challenges*

- 7.77 In the same way that common tasks or challenges had often brought health engagement with spatial planning in the first place, the development of any resulting partnership can help maintain a degree of momentum. In other words, in most of the study areas, some current or future task could be identified which was giving confidence of future collaborative work. As examples, in Stoke is the work to bring SCS into line with the developing JSNA, in Manchester it is the current work on the core strategy.
- 7.78 In Tower Hamlets, practitioners claimed that the key factor in making their partnership work was the high priority given by both organisations to a healthy community in a borough with huge challenges. "*Inertia and lack of delivery is not an option*" and there appears to be strong leadership from the LSP and the senior management in both organisations. This positive attitude followed an audit in 2000 that the borough lacked effective leadership, and since then there have been significant improvements.

### *Skills*

- 7.79 In advance of the case studies, there had been several pointers to the possibility of there being potentially a skills gap in terms of planners and health professionals being able to engage in their respective decision-making processes. However, what emerged from the research was a little different. No-one appeared to believe there is a real skills gap - or at least not one that was particularly critical: the issue was no more than a lack of awareness and knowledge of the other's activities, and this could be easily remedied provided that engagement occurred in the first place.

### *Commitment*

- 7.80 Frequent mention was also made of PCT staff failing to turn up for meetings and other events for which they had agreed participation. Typically, this was accompanied by expressions of understanding for the workload of the respective PCT staff; but at the same time there was an implication that PCTs may not be sufficiently committed to engagement in spatial planning. This problem appeared to be exacerbated by liaison with planning not being explicitly in job descriptions.

### *Accessibility*

- 7.81 Knowing who to contact is valuable, but actually being able to make that contact can be of critical importance. This was occasionally brought into clear profile when researchers in

the study had problems in this respect. A PCT officer with a comparable experience stated that “*contacting planners is like catching paper in the wind*”, although no basis was found for suggesting that the situation regarding PCT staff was any better.

### *Catalysts*

- 7.82 An example was found where the appointment of a senior person to a PCT had transformed the effectiveness of its involvement in spatial planning. The impact of this appointment was further enhanced through the 18-24 month hiatus created by a former director with an interest in engagement with planning having left the PCT.

### *Continuity*

- 7.83 Many contributors to the research, from both planning and health sides, expressed concern at the impact of high rates of turnover and frequent changes of responsibility among PCT staff.
- 7.84 Yet, in Tower Hamlets, this was not viewed as a significant problem. Despite significant changes of staff over the previous 5 years, the arrangements in place there (see §6.31) appeared to have permitted continuity in practice and policy to be maintained.

### *Resources*

- 7.85 While resource constraints appeared to be a universal challenge, the resources needed to make a success of engagement did not appear to be assessed as being more than a marginal addition to overall staff time. Making the necessary resources available could therefore be viewed as a matter of prioritisation within the respective PCT and local authority. Clearly, where health issues are given priority, the evidence suggests that effective engagement of health in planning processes should be possible.
- 7.86 Nonetheless, for those who have attracted additional funding - e.g. Healthy Borough in the case of Tower Hamlets - there is no doubt that this helps a great deal.

### *Strategy*

- 7.87 It is very much easier to integrate health into spatial planning when both are policy-driven, and when the policies are aimed at achieving the same objectives, at least with respect to health outcomes. Additionally, there needs to be a common acceptance of the need to improve working arrangements to deliver these tangible outcomes, and a mutual

acceptance of the need to monitor them. One health practitioner claimed that locally this favourable situation is in the process of emerging, and set out an agenda for immediate action to help bring it about:

- embedding the new approach in the working culture of both organisations
- developing effective monitoring systems
- jointly driving the creation of new policy
- improving the skills and knowledge of officers and members on both sides
- developing an enhanced evidence base

### *Success*

- 7.88 It is possible that the most critical factor favouring health engagement in the spatial planning process is the achievement of success itself. Certainly, examples found in the case studies pointed in this direction: there was an evident sense of pride in what had been achieved, and the very fact of achievement appeared to make it easier to contemplate further joint working, building on the perceived success. That “success breeds success” is not simply a truism.
- 7.89 Recognising the value of having achieved success is of limited value for those not in that privileged position. Nonetheless, it could provide a degree of reassurance for those wondering whether the effort involved in attempts to initiate engagement will prove to be worthwhile. Of more immediate value, however, is perhaps the possibility of demonstrating success elsewhere as a means of overcoming resistance in a particular area. The value of publicising examples of good practice - for which read “success” in this context - was one of the issues promoted by attendees at the workshops.





## Appendix A: Questions for Document Reviews

A.1. The following sets of questions were drawn up in advance of the document reviews in order to impose a systematic approach to the examination of individual documents.

### National Policy Guidance on Spatial Planning

- Does the guidance document mention healthcare provision (surgeries, clinics, etc.) as an element of land use or infrastructure which should be covered by spatial planning?
- Does the document make any reference to wider issues of health and wellbeing (i.e. on the health of individuals or communities, on health services, on public health, or on health inequalities)?
- Does it set out how planning might affect health? And if so, is this in terms of generalities, specifics and/or examples?
- Does it draw attention to the possibility that the spatial planning on which guidance is provided could impact on health?
- Does it state or imply that the spatial planning will probably impact on health and therefore require these effects to be taken into account in decision-making?
- Does it require the planning to address desirable outcomes for health to be addressed as aims or objectives?
- Does it require health issues to be addressed through some form of impact assessment of planning outputs, or is any impact on health to be incorporated into the decision-making processes through which these outputs are produced?
- Does the document provide any guidance on how health issues are to be handled?
- Does it specify or imply the format of any planning outputs if they are to be related to health issues?
- Are any health bodies identified as stakeholders, consultees or otherwise interested parties in the planning process? - is engagement with the health sector a requirement or optional?
- Is there any guidance on how and when to engage health bodies?

- If any case studies or examples of good practice are included in the guidance, do any include coverage of health issues?
- Are there any references to other documents which would provide relevant information on, or an explanation of, appropriate health issues or elements of the health sector?

## National Policy Guidance on Health Matters

- Does the guidance document make any mention of spatial planning (or land use, town, regional, strategic planning, or local development frameworks, etc.) as a element of land use or infrastructure which should be covered by spatial planning?
- Does it recognise decisions within the planning system as a factor that can impact on health and well-being?
- Does it set out how planning might affect health? And if so, is this in terms of generalities, specifics and/or examples?
- Does the guidance identify the various decision-making elements/levels/processes within the planning system? - i.e. RSS, LDF, core strategy, development control decisions, etc., etc.
- Does it differentiate between these decision-making elements in relation to the potential type and significance of effects on health?
- Does it encourage or require engagement of health bodies in decision-making processes in planning? If so, does it describe how, when and with what intended outcome this engagement should take place?
- If any case studies or examples of good practice are included in the guidance, do any include coverage of engagement in spatial planning?
- Are there any references to other documents which would provide relevant information on, or an explanation of, spatial planning or elements of the planning system?

## Regional Spatial Strategies

- Does the strategy mention healthcare provision (surgeries, clinics, etc.) as an element of land use or infrastructure which is specifically covered in its provisions?

- Does any element of healthcare provision actually appear in any formal policy as something that will be directly influenced by that policy? Does the policy require specific action by local authorities in their LDFs?
- Does the document make any reference to wider issues of health and wellbeing (i.e. on the health of individuals or communities, on health services, on public health, or on health inequalities)? Does it refer to health inequalities?
- Is there any mention of health issues among the formal goals, aims or objectives set for the strategy? And if so, does this constitute one or more specific intended outcomes from implementing the strategy, and would such outcomes be measurable?
- Is there recognition that implementation of the strategy might affect health? And if so, is this in terms of generalities, specifics and/or examples?
- Are any health indicators included in the proposed monitoring framework?
- Is there any policy included in the document which is intended to deliver health outcomes? Is there an indicator included in the monitoring framework which specifically monitors success in achieving the respective outcomes?
- Does it draw attention to the possibility that spatial planning at the local level could impact on health? Does it require this to be taken into account as a factor in decision-making in the production and implementation of LDFs?
- In the Strategy or supporting documents, have health issues been addressed through any form of impact assessment during the production of the strategy? And if so, at which point(s) in the process was this, and is there any evidence of the strategy having been informed or influenced by consideration of the potential impact on health issues.
- Are any health bodies identified in the documentation as having been stakeholders, consultees or otherwise interested parties in the planning process? Which?
- Is there any indication of the input from health bodies to the process, or evidence of what influence they may have had?
- Are there any specific references to health among the “matters” considered in the formal Examination in Public of the draft strategy? What reference to health issues is there in the report produced by the Examination Panel?

## Local Development Frameworks

- How strong is the relationship between the SCS and LDF? (in terms of content, goals and objectives, prioritisation, strategic direction, etc.)
- Does the core strategy mention healthcare provision (surgeries, clinics, etc.) as an element of land use or infrastructure which is specifically covered in its provisions?
- Does the document make any reference to wider issues of health and wellbeing (i.e. on the health of individuals or communities, on health services, on public health, or on health inequalities)? And if so, does this correspond with the Sustainable Community Strategy?
- Is there any mention of health issues among the formal goals, aims or objectives set for the strategy? And if so, does this constitute one or more specific intended outcomes from implementing the strategy, and would such outcomes be measurable? And if so, does this correspond with the Sustainable Community Strategy?
- Is there recognition that implementation of the strategy might affect health? And if so, is this in terms of generalities, specifics and/or examples?
- Are any health indicators included in any proposed monitoring framework?
- Is there any policy (or “priority”) included in the document which is intended to deliver health outcomes?
- Does it draw attention to the possibility that decisions on individual development schemes or projects could impact on health? Does it require this to be taken into account as a factor in decisions taken in managing such developments?
- In the Strategy or supporting documents, have health issues been addressed through any form of impact assessment during the production of the strategy? And if so, at which point(s) in the process was this, and is there any evidence of the strategy having been informed or influenced by consideration of the potential impact on health issues.
- Are any health bodies identified in the Statement of Community Involvement? Which?
- Is there any evidence of engagement by health bodies in the process, or evidence of what influence they may have had?
- Are there any specific references to health among the “matters” considered in the formal Examination in Public of the draft strategy? What reference to health issues is there in the report produced by the Examination Panel?

- If Area Action Plans have been drafted, what evidence is there of health issues in the core strategy being properly taken over into their provisions?

## **Local Initiatives to Integrate Health into Planning**

- What is the origin of the initiative? Where did the impetus derive?
- Does the documentation of the initiative set out clearly its objectives, methodology, participants, timescale, etc.?
- Were there conclusions regarding factors determining success?
- Were there recommendations of relevance to our study?
- Were there recommendations for research?
- Were any examples of practice potentially of value as case studies for us?

## Appendix B: Selection of LDFs for Review

- B.1. The intention was for the study to examine the LDFs of between 10-15 areas across the country. The approach to the selection of these areas was to seek a means of generating a list of cases in which evidence ought to be expected of efforts being made to incorporate considerations of health into the decision making for local spatial planning. The criteria used were:
- Where a core strategy is in place and has been judged by the Planning Inspectorate to be sound;
  - Where work on the core strategy lies within the most recent past, i.e. maximising the likelihood that health considerations may have played a role in response to growing awareness of their importance; and
  - Achieving a maximum spread across geography and area type.
- B.2. In order to apply these criteria, the chosen starting point was the latest information on LDF assessments as presented on the website of the Planning Inspectorate<sup>13</sup>. This revealed - valid at 23<sup>rd</sup> March 2010 - that 249 DPDs had been submitted for processing by the Inspectorate. Of these, 113 related to Core Strategies, broken down as follows:
- 19 withdrawn by the submitting authority before decision,
  - 8 judged to be unsound,
  - 30 pending, and
  - 56 judged to be sound<sup>14</sup>.
- B.3. Of the 56 core strategies which had been submitted and judged to be sound, 14 had been submitted during the period since 1<sup>st</sup> April 2008. Therefore, restricting the sample to submissions during the most recent two financial years could provide the target sample size. The resulting sample of 14 areas (see Table 3.1) provides a reasonable spread across geography and area type. 13 of the sample of 14 were reviewed, concentrating on the Core Strategies that, with the exception of Barking and Dagenham, had been through the whole approval process. Each Core Strategy was looked at in relation to questions designed to test their health content. Important supporting documents were also reviewed, mainly using a word-search technique. These included the relevant Sustainable

<sup>13</sup> [http://www.planning-inspectorate.gov.uk/pins/appeals/local\\_dev/dpd/submitted\\_dpd\\_mar\\_10.pdf](http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/dpd/submitted_dpd_mar_10.pdf)

<sup>14</sup> An observation made at the workshops provides some context to the status of "sound": because health issues are not enshrined in government guidance on planning policy, they tend not to be picked up by planning inspectors when spatial plans are being examined.

Community Strategy, Sustainability Appraisal, Examination in Public documents including 'matters' selected for hearings and the Inspector's report, Schedule of Changes, etc.

**Table B.1: LDFs selected for the document review**

Area	Region	Area Type	PCT area(s)	Documents
East Cambridgeshire	EofE	shire district	Cambs	Core Strategy + Development Control Policies
Huntingdonshire	EofE	shire district	Cambs	Core Strategy (second)
Mid Beds	EofE	shire district	Beds	Core Strategy + Development Control Policies
Hinckley & Bosworth	EM	shire district	Leics.	Core Strategy
Barking & Dagenham	London	London borough	Barking & Dagenham	Core Strategy
Sutton	London	London borough	Sutton & Merton	Core Strategy
Northumberland National Park	NE	National Park	Northumberland	Core Strategy + Development Policies
Dover	SE	shire district	East Kent	Core Strategy
Mole Valley	SE	shire district	Surrey	Core Strategy
New Forest	SE	shire district	Hants	Core Strategy
Southampton	SE	unitary	Southampton	Core Strategy
Wokingham	SE	unitary	Surrey	Core Strategy
Poole	SW	unitary	Bournemouth & Poole	Core Strategy
N. Staffordshire (Stoke + Newcastle)	WM	joint	Stoke / N. Staffs	Joint Core Strategy

Source: Planning Inspectorate Website



- B.4. Due to the fact that most Core Strategies reviewed had been recently adopted, Area Action Plans and other associated DPDs were frequently found to be in preparation and in the process of approval. These were therefore not studied in any detail.

## Appendix C: Stakeholder Interviews

c.1. In the initial planning of the study, a series of broad questions was drawn up to be posed to a selection of stakeholders:

- Perception of the interface between health and spatial planning;
- Current interaction between stakeholders and how it is developing, e.g. through local strategic partnerships;
- Experience with health involvement in specific elements of spatial planning e.g. regional spatial strategy and/or the local development framework
- Experience with health involvement in specific “tools” of spatial planning, e.g. sustainability appraisals, environmental impact assessments, health impact assessments, etc.;
- Experience with integration of health and spatial planning in formal processes relating to sustainable community strategies;
- Initiatives taken - successes and failures, the reasons why, and lessons learned;
- Suggestions of good practice;
- Recognised opportunities for enhancing processes and good practice further, or for setting up new approaches; and
- Identification of any blockages, or problems with skills, resources, etc.

c.2. Once the study had begun, a slightly different approach was thought more likely to elicit valuable information from the wide range of interviewees: posing a smaller number of very broad questions in order to generate a more discursive discussion around the topic. A number of additional questions were held in reserve to be used as and when needed as prompts or supplements, should this be needed to ensure that the intended subject matter could be covered - as shown at the end of this appendix (pp.109-110).

c.3. These questions were then used in telephone interviews with a number of people selected to represent a sample of organisations which might be considered as “stakeholders” in the issue of integrating health into spatial planning. The initial plan for the study was to conduct around 20 interviews with a selection of stakeholders at national, regional and local level, and covering both planning and health perspectives. A perusal of the 50+ organisations formally registered with NICE as stakeholders for this project provided an

insight into the scale of the potential population from which a sample of stakeholders was to be drawn. In reality, given the breadth of different backgrounds from which potential stakeholders in the subject of the study could be drawn, the numbers of organisations involved were potentially very large, counted in hundreds.

- c.4. It was, of course, possible for a sample to be drawn at random. However, in preference to this, it was decided first to structure the population into broad groups; and then to apply some selection criteria to provide a sample offering good coverage, using knowledge and judgement. In terms of coverage, a critical requirement was to have the opportunity to receive information from every region, and hence maximise the chance of potential candidates for case studies being identified in each.<sup>15</sup>
- c.5. The 25 organisations which were targeted in this process are given in Table C.1. It was not possible to interview all representatives from the target sample of organisations; although some success was achieved in finding suitable replacements.

**Table C.1: Target Sample of Stakeholders for Interview**

<p><b>National bodies:</b>            Department of Health*            Communities and Local Government*            Improvement and Development Agency*            Planning Inspectorate            Planning Advisory Service*            ATLAS*            Royal Town Planning Institute*            Planning Officers Society            Local Government Association            CABE*            a leading architect and planning practice</p>	<p><b>Regional Government Offices:</b>            GONW            GOSE            GOSW</p>
	<p><b>Regional LGA or similar:</b>            Greater London Authority*            East Midlands Councils            WM Leaders Board</p>
<p><b>Local authorities:</b>            Dudley Metropolitan Borough Council            Stoke-on-Trent City Council            Luton Borough Council / PCT (joint)</p>	<p><b>Health bodies:</b>            London HUDU*            East of England PCT Network*            Newcastle PCT*            NHS Stoke-on-Trent*            NHS Yorkshire and Humberside</p>

*\*Represented among stakeholders officially registered with NICE for this project.*

<sup>15</sup> It should be noted that, outside of London, the regional assemblies formerly responsible for RSSs had been dissolved at the end of March 2010. The transfer of responsibility to the regional development agencies and new bodies representing local councils resulted inevitably in the loss of key staff who could have been targeted for interviews. Only two of these “inheritance” bodies were therefore included in the sample.

**Question 1: What are the main health issues you think planners should take into account - when they are preparing spatial plans and/or making decisions on individual applications?**

*Possible prompts:*

- a. Should they address Government/NHS agenda for “health and wellbeing”?
- b. Should they address health inequalities?

**Question 2: Do you think health issues are being properly taken into account in decisions on spatial planning at the local level?**

*Possible prompts:*

- c. Are local planners normally aware of the possibility that their decisions and actions might impact on health? Do they understand how the impact works?
- d. Do they feel obliged to take account of health issues when making their decisions? - and at which points in planning processes does this apply?
- e. What degree of importance do you believe planners actually attach to the possible impact on health of their decisions? What might determine this?
- f. Do you believe that planners normally consult health professionals or health bodies in relation to planning processes? Is this a mere formality? What is the usual response from the health sector?

*Possible supplementaries:*

- g. Is the Government’s “NHS” agenda for health and wellbeing being picked up sufficiently in sustainable community strategies etc. which provide the framework for local spatial plans?
- h. Where do you think planners obtain their information on the health matters relating to their decisions?

**Question 3: Is the health sector engaging effectively with local spatial planning?**

*Possible prompts:*

- i. Are health professionals interested in influencing spatial planning?

- j. Do they actively seek to influence planning decisions? Do they believe they can influence them?
- k. Does the health sector know how to engage in planning processes? Do they have staff with the requisite knowledge and understanding?
- l. Does any mismatch between LA and PCT boundaries play a role?

**Question 4: What are the key obstacles which might prevent health issues being fully taken into account in local spatial planning decisions?**

**Question 5: Are you aware of examples where there has been significant and real influence of health issues on planning decisions?**

*Possible prompts:*

- m. What do you believe were key factors in achieving success?
- n. From where did the initiative come?
- o. Would you describe the working arrangements as formal or informal?
- p. Were particular tools or methodologies used which supported joint working?
- q. Do any of these represent “good practice”?

**Question 6: Would you recommend any less successful cases for us to examine so that lessons might be learned?**

*Possible prompts:*

- r. Examples where real attempts were made by health professionals to influence planning processes, but where this failed? Do you know the reasons?
- s. Examples of planners attempting to engage the health sector but being rebuffed?
- t. Examples where both sides made serious efforts but there was still a failure to integrate health into spatial planning?

**Question 7: In summary - What key messages do you think the proposed NICE guidance should give to planners and to health professionals?**

## Appendix D: Research Questions

### Theme 1: How is Health addressed in Spatial Planning Decisions?

- D.1. This theme looked at the processes of spatial planning and certain factors relating to how the possibility of health outcomes is taken into account in decision-making.

#### *Knowledge of Health among Planners and Council Members*

- Q** Do planners attach importance to keeping up to date on changes to national policy on health? If so, how do they do this?
- Q** Is there an effective mechanism for communicating to planners any changes to health policy as it affects them? If not, how might better knowledge influence spatial strategy?
- Q** Does the content of formal planning guidance actually equip planners with an understanding of the national health agenda, of how their decisions can affect health, and of what roles they are expected to play in pursuit of that agenda? Are planners actually aware of all the guidance which covers this area? If not, why not?
- Q** Do planners obtain from formal planning guidance a clear picture of at what stages and in what ways health outcomes need to be taken into account in their work?
- Q** If there are inadequacies in the above areas, are planners on the ground aware of them? Are they able to articulate where more or better guidance would be needed? Can they suggest the most effective format for addressing these needs? - is it a matter of improving on current means of guidance, or is there a requirement for more radical change?

#### *Expectations on Local Spatial Planning imposed by Regional Strategies*

- Q** Does the RSS contain policies addressing health issues which require action in LDFs? Are local planners fully aware of them? If so, are they picked up fully in the content of the Core Strategy and any other LDDs?

- Q If work on the LDF predated finalisation of the RSS, how was the lack of strategic guidance handled?
- Q Have local strategic planners experienced difficulties in interpreting regional policies in terms of their implications for their area? If so, what has been done to rectify this?
- Q Have local planners taken notice of the supporting texts relating to health in the RSS, particularly where this actually provides guidance on interpreting policies?
- Q Is the monitoring framework of the RSS designed to assess success in achieving the health outcomes intended in its policies? Is information being collected at the local level accordingly?

### *Expectations imposed by the Local Sustainable Community Strategy*

- Q Does the Sustainable Community Strategy include objectives relating to health? Have planners translated these directly into objectives for the LDF? If not, how is this explained?
- Q Does the LSP show any sign of identifying spatial planning as a vehicle for delivering health outcomes?

### *The Planners' Evidence Base*

- Q How is evidence handled by planners in drawing up policies? Does the presentation of material allow linkage to be followed?
- Q Is the approach to health in planning actually based on evidence and understanding of how the one creates outcomes in the other? If not, how do they approach the challenge of integrating health issues into planning when decisions are supposed to be evidence-based?
- Q What sources of evidence are used by planners in relation to health? How is it selected?

- Q Is there joint working on baseline data, and/or is there a common database? Is the JSNA used? (If a lower-tier local authority, was there involvement in the JSNA?)
- Q Are planners working to a framework of principles and standards when addressing health issues in their work? If so, do these relate to an evidence base?

### *Development Management*

- Q Are current development control policies part of the LDF (approved?), or do they relate back to an earlier framework? Do they make specific reference to health - outcomes, facilities, etc.?
- Q Are health bodies actively involved in the decision-making processes for assessing and determining planning applications, and under what circumstances? If not, how are health issues taken into account?
- Q Are potential developers required to consult or work with health bodies in preparing their planning applications? - and if so, on what basis?
- Q If a HIA is required for major developments, is there any policy guidance on (a) how the results will be interpreted or otherwise addressed? Or (b) what should be done and who should do it?
- Q In London, is the HUDU model used to assess developer contributions? - and if not, why not? Elsewhere, how are health facilities addressed in s106 negotiations?

## **Theme 2: How do Health Professionals view the Planning Process?**

- D.2. This theme looked at spatial planning from the perspective of health professionals, trying to identify factors which influence whether and how they might seek to engage in spatial planning.



### *Health Professionals' Knowledge of the Spatial Planning Process*

Q Does formal guidance to health professionals provide them with sufficient knowledge and understanding of the spatial planning system, and how it might impact on health, to equip them with an ability to engage effectively in planning decision making? Are those health professionals with responsibilities for JSNAs, LSPs and Sustainable Community Strategies aware of how these relate to spatial planning? If not, why not?

Q If there are inadequacies in the above areas, are health professionals on the ground aware of them? Are they able to articulate where more or better guidance would be needed? Can they suggest the most effective format for addressing these needs? - is it a matter of improving on current means of guidance, or is there a requirement for more radical change?

### *Expectations on Health Professionals to get involved in Spatial Planning*

Q Is the local Sustainable Community Strategy viewed as committing health bodies to involvement in spatial planning?

Q Do targets in the LAA necessitate engagement with spatial planning?

Q Does any evidence of need in the JSNA point to benefits from influencing spatial planning decisions?

Q Do any local health initiatives or the contents of strategies or plans in the health sector impose an expectation on health professionals' engagement with spatial planning?

### *Motivation for Health Involvement in Spatial Planning*

Q Which health organisations and individuals are or have been involved in spatial planning processes?

Q Do health professionals believe that spatial planning can influence health inequalities and other health outcomes? Why? What is their evidence?

Q How do we make health see the value of engaging with planning?

Q Do health professionals believe that they can influence spatial planning decisions? Which? And in what way do they believe influence can be exercised?

### Theme 3: How do Planners and Health Professionals interact?

D.3. In theme 3, the focus shifted to the interaction between health professionals and planners in general, and particularly in the context of spatial planning processes.

#### *Culture*

Q How do planners view the knowledge of spatial planning arrangements found among local health organisations and professionals with whom they come into contact? How do the latter view planners' knowledge of health issues?

Q Has engagement been a learning exercise? - Have planners and health professional been able to fill gaps in their existing knowledge (e.g. from guidance) through engagement with colleagues across the health/planning interface?

Q Do planners and health professionals speak a common language? If not, do they find it easy to develop one for effective communication?

Q What are the significant cultural differences? How do we overcome them?

Q Is there a skills gap in terms of planners and health professionals being able to engage in their respective decision-making processes?

#### *Arrangements for Collaboration between Planners and Health Bodies*

Q Are there formal arrangements (e.g. engagement agreement) for health bodies being engaged in local strategic planning decisions which go beyond the statutory letter of consultation? At what stages of the processes? What is the response?

- Q Has there been informal collaboration between health professionals and planners in spatial planning decisions? What form does this take? Who took the initiative? Is it an extension of LSP cooperation?
- Q For the PCT, which departments/personnel are actually involved with planners? Are they able to represent the PCT corporately? Are they the same as involved in LSP and SCS work? Are they able to involve/inform PCT decision making in the right areas and levels?
- Q What impact has the work of the SCS had in bringing people from health and planning together to work more closely? Has the SCS been key to current arrangements?
- Q Who is responsible in the planning department for health coordination? Is this direct or via environmental health colleagues? Are there internal arrangements to integrate this with other local authority activities corporately and externally, e.g. through the LSP?
- Q Do the arrangements work to the satisfaction of all concerned? How do they actually assess whether they work? What were the expectations? Who takes responsibility in ensuring that the arrangements work?

### *Effectiveness of the Arrangements*

- Q Does the PCT involve the local authority in its own 5-year strategies, capital programme reviews, etc.? If not, why not? Have these exercises been coordinated with the SCS and LDF work - particularly the LDF investment/infrastructure plan? How has the PCT been involved in these plans generally?
- Q If planning and health professionals have begun to work together more closely, is this based on established historic relationships, or have new ones formed? If so, was this the result of a specific decision, or work on a particular scheme? What were the motives? - do they reflect a recognition of the need to work more effectively together?
- Q If difficulties are experienced, what is the explanation? What has been undertaken to address any difficulties, and with what result?

- Q How reliant are working arrangements on particular individuals? If any of the individuals left would the arrangements continue?
- Q Are problems experienced in synchronising the timescales to which spatial planners and health professionals are operating? How do we make the long term timeframe for planning relevant to the way Health work?
- Q To what extent are resources - quality and quantity - a factor in determining the nature of engagement of health interests in planning decisions?
- Q Which are the critical factors in determining whether arrangements do or do not work?

## Theme 4: How can Concern for Health Outcomes influence Spatial Planning Decisions?

- D.4. This theme pursued a more challenging agenda, building on the others. The questions here were generally probing into the spatial planning process to identify the practical issues of trying to address health issues in a manner which is meaningful to spatial planning processes.

### *Health Outcomes in Spatial Planning*

- Q How does the regional /national level (including macro-economic factors) influence how health issues are considered?
- Q Is there an understanding of how spatial planning can benefit health outcomes e.g. the wider determinants of health such as greenspace, better walking/cycling, better housing conditions, etc.? How is this articulated?
- Q Are strategic objectives which relate to health in the Core Strategy formulated in a manner which allows the level of achievement in meeting them to be assessed or measured?

- Q Is there coherence in local health objectives and how they are to be addressed in policy terms - in general and specifically in terms of spatial planning? How can this be explained?
- Q To what extent are local council members involved in the “health agenda” in spatial planning? To what extent do they understand this dimension of the planning framework?
- Q What level of priority is attached to health objectives in planning?
- Q Do health professionals understand that spatial planning decisions involve compromises between competing objectives?

### *Tools and Techniques*

- Q Have particular tools or techniques been used to assist in addressing health issues in local spatial planning processes? If so, which? - Are they concerned only with the impact of planning decisions on health, or do they range more widely across the interface?
- Q Have local planners been actively involved in the use of health-related tools, or were they applied by consultants? In what way were local health professionals involved? Do the planners “own” or understand the results?
- Q Have the tools or techniques been used to inform decision making throughout the planning process, or only in assessing the impact of a “finished product”?
- Q Have results from the JSNA been used in formulating the LDF? Were planners involved in the JSNA?
- Q Has use of such tools brought about a learning process for those involved?
- Q What principles and standards are needed to ensure both the quality of the health assessment process and its impact on spatial planning decisions?

## *Wider Issues relating to Engagement*

- Q What resources (including skills, expertise, information, evidence, finance) are available to support the process of health engagement in spatial planning? Are they sufficient? Are they symmetrical, supporting a “balanced” process?

## *Monitoring*

- Q Are health-related policies couched in terms which facilitate the monitoring of (a) whether they are being applied and (b) whether they are being successful? Does the relevant monitoring framework require these to be monitored - i.e. evidence to be collected that will properly demonstrate the achievement of health outcomes?
- Q What are planning authorities doing to measure health outcomes - e.g. inequalities, morbidity, etc.?
- Q Are they monitoring health indicators, e.g. walking, cycling, use of open space, etc.? Are these then related to health outcomes themselves?
- Q Are there problems related to the lack of evidence of health outcomes? - either because not monitored, or because too far in the future. Do planners actually have any evidenced picture of the real effect of their planning decisions?

## Appendix E: The Case Studies

E.1. At the outset of the study, the intention was to select between 5-8 case studies to be undertaken, each covering a specific geographical area which is believed to have something to offer in an examination of the integration of health into spatial planning. A primary purpose of the research in phase one of the study was to facilitate the selection of suitable case studies.

### Approach

E.2. The research questions set out in the previous chapter represented the starting point in each case study. All case studies would be addressing unique situations, and it was imperative from the start to be prepared to tailor the set of research questions to each individually. This process was initially informed by a review of local documents available on the internet; it was then refined through engagement with the local actors on the ground.

E.3. The core actors who would be targeted in each study were expected to include representatives from the following:

- Local authority/ies
  - Forward planning (LDF)
  - Development management
  - Transport
- Local Strategic Partnership
- PCT
  - Partnerships
  - Strategy
  - Estates / property services

Other local players would then be brought in as appropriate once their relevance were identified.

- E.4. The conduct of interviews with these actors was designed to elicit information which would then permit the researcher to address the research questions agreed for the study. Only occasionally would this necessitate the research question per se to be posed to the local actor. More commonly the researcher was required to steer discussion around the relevant issues, challenging responses, seizing opportunities to explore in depth where this proved beneficial, and following up new avenues of investigation when these arose. Through this flexible approach targeting the fundamental questions, it was possible to obtain considerable insight into the practical issues experienced on the ground. It also increased the likelihood of getting behind what might otherwise have been interviewees presenting a “corporate line”. This likelihood was enhanced by assurance of anonymity.
- E.5. In total, 61 (confirm ???) individuals were interviewed during the seven case studies, representing different departments in 25 (check ???) separate organisations.

## Selecting the Case Study Areas

- E.6. It is important to remember that the aim of selecting case studies was not to support a quantitative analysis of health integration into planning, but rather an in-depth qualitative study. There was consequently no imperative for the areas to be representative in any statistically meaningful way. Nor was it necessary to have identified the areas in which most progress had been made in linking health and planning. While the study would identify good practice if it were found; in many respects it was even more important to be exploring what could be viewed as more common, or “normal” practice.
- E.7. The criteria originally proposed for selecting case studies were:
- Type of geographical area
  - Type of situation found on the ground with respect to effort and success in integrating health into spatial planning.
- E.8. The criteria which emerged during the study as being possibly critical in respect to geography were
- Unitary vs. 2-tier authority structure
  - Metropolitan vs. non-metropolitan (or rural)
  - Congruity between PCT and local authority areas
  - Regional location



- E.9. In practice, the quality of information emerging from the document reviews and stakeholder interviews was insufficient to permit good differentiation to be made in areas' respective performance in integrating health into planning. For this reason, the main driver in selecting case studies was a good spread of geographical types.
- E.10. At the end of phase one of the study, a shortlist of 12 areas was created by pooling all the information gleaned on potential candidates around the country, paying particular attention to the geographical spread. The relative merits of these were discussed with NICE, resulting in a final selection of seven areas to be the subjects of the case studies.
- E.11. The resulting seven case study areas are described below.

## Bexley

- E.12. The London Borough of Bexley - a unitary authority - is located in the Thames Gateway and extends from the river Thames in the north to the greenbelt of the Kent countryside in the south. It has a suburban identity resulting from large areas of inter-war housing with relatively large gardens and a number of small towns and villages within it. Areas close to the Thames, which have seen diversification of employment resulting from their industrial legacy, also suffer higher multiple deprivation and crime and have been targets for improvement and regeneration.
- E.13. The Core Strategy is in preparation, and a number of key consultations have taken place since 2006.
- E.14. The Borough's area is coterminous with that of the PCT, Bexley Care Trust. The Audit Commission judged the PCT's performance to be adequate in its 2009 organisational assessment<sup>16</sup>.
- E.15. In a 2008 report from the Audit Commission<sup>17</sup>, the judgement was reached that "The Council's planning service works well to support the delivery of its ambitions. Planning policies support the delivery of Council initiatives, particularly in economic regeneration and housing" (p.26). The Borough was assessed as performing well overall in an Audit Commission report in 2009<sup>18</sup>.

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<sup>16</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=51&area=310&orgId=1013>

<sup>17</sup> <http://www.audit-commission.gov.uk/SiteCollectionDocuments/InspectionOutput/CorporateAssessments/CorporateAssessmentReport.pdf>

<sup>18</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=51&area=310&orgId=1012>

## Hinckley and Bosworth

- E.16. The area covered by the Borough of Hinckley and Bosworth lies in the south-west quarter of Leicestershire. It is very mixed, with a predominantly urban population but extensive rural areas experiencing health provision issues. The decline of employment in the former coalfield and traditional hosiery and other industries has left pockets of deprivation, which are often close to quite prosperous communities.
- E.17. The Borough is a lower-tier authority sharing the county of Leicestershire with six other authorities. The PCT, NHS Leicestershire County and Rutland, covers the named county and unitary authority. Its performance was as judged to be adequate in the Audit Commission's organisational assessment in 2009<sup>19</sup>. The County Council's performance was assessed as excellent<sup>20</sup>.
- E.18. In its 2009 organisational assessment, the Audit Commission judged Hinckley and Bosworth Borough Council to be performing well<sup>21</sup>.
- E.19. Also at the end of 2008, the Core Strategy was adopted by the Borough Council and judged to be sound by the Planning Inspectorate a year later. This followed the equivalent process for the East Midlands Plan with which it had to conform.

## City of Manchester

- E.20. The City of Manchester occupies an irregular area at the heart of the Greater Manchester (GM) conurbation, and the council work with the other unitary authorities in the Association of Greater Manchester Authorities (AGMA). Consequently, spatial planning at the GM level provides an important context for that in the city. The importance of the GM dimension has actually been growing in accordance with the local authorities' joint aspiration for the conurbation to be recognised as a combined authority, and a bid to become a "local enterprise partnership" has been made in 2010.
- E.21. Manchester was an early member of the WHO Healthy Cities Programme. The city generally displays some of the worst health statistics among local authority areas, and stark health inequalities within the city can be recognised in association with some of the

<sup>19</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=49&area=375&orgId=1381>

<sup>20</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=49&area=375&orgId=1380>

<sup>21</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=49&area=375&orgId=1376>

worst ill health and general deprivation in the country. NHS Manchester is the local PCT with area boundaries coterminous with the city. The Audit Commission assessed its performance in 2009 to be adequate<sup>22</sup>. All the PCT's in Greater Manchester work together in a joint structure to cooperate with AGMA.

- E.22. Work is well advanced in the preparation of the core strategy for the city, with the intention of adoption before the end of 2010.
- E.23. A 2009 organisational assessment report from the Audit Commission<sup>23</sup> judged the City Council to be performing well overall, “*effectively and imaginatively through partnerships to deliver its priorities*” (p.6).

## Somerset

- E.24. Somerset is a predominately rural county with a population of about 525,000. The main towns are Taunton, Yeovil and Bridgwater, but none has a population over 100,000.
- E.25. Administratively, the county has a two-tier structure with 5 district councils - Mendip, West Somerset, South Somerset, Taunton Deane and Sedgemoor. In the most recent organisational assessments by the Audit Commission, the County Council<sup>24</sup> and South Somerset District Council<sup>25</sup> were judged to be performing well, while the others' performances were either adequate or poor. There is a single PCT covering the county, which was assessed by the Audit Commission in 2009 to be performing well<sup>26</sup>.
- E.26. Life expectancy in Somerset is relatively high (78 years for men and 82 years for women) and is increasing, but the expectancy of a healthy life is not increasing as fast, suggesting that more people will be living with ill health in future and there is likely to be an increase in the incidence of dementia and life limiting conditions.
- E.27. All of the districts are currently working to produce a core strategy, and none has yet been adopted. The Planning Inspectorate approved an Area Action Plan in Taunton Deane in 2008.

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<sup>22</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=53&area=380&orgId=1405>

<sup>23</sup> <http://www.audit-commission.gov.uk/SiteCollectionDocuments/InspectionOutput/CorporateAssessments/ManchesterCorporateAREP.pdf>

<sup>24</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=54&area=404&orgId=1517>

<sup>25</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=54&area=404&orgId=1514>

<sup>26</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=54&area=404&orgId=1518>

## South Cambridgeshire

- E.28. Like Hinckley & Bosworth, South Cambridgeshire is one of five districts within the county of Cambridgeshire, in other words a lower-tier authority in a two-tier structure. It covers an area of massive development pressures in the most dynamic growth area outside of London. Yet it is largely rural with no communities over 8,000 people (in 2007), but borders on the City of Cambridge and is surrounded by a number of market towns. With over 142,500 residents (in 2008), it already has a larger population than Cambridge itself, and further substantial growth is planned, particularly in the form of major urban extensions to the city.
- E.29. The District's core strategy was adopted in 2005 and approved as "sound" the following year, i.e. preceding the East of England Regional Spatial Strategy. Several Area Action Plans for growth areas have also been approved since then, produced jointly with the City of Cambridge.
- E.30. South Cambridgeshire generally fares better than the national average for health indicators. It has no wards in the 20% of most deprived wards in Cambridgeshire, and has the highest life expectancy for both males and females of any district in the county. One indicator where South Cambridgeshire fares worse than the national average is road injuries and deaths. Cambridgeshire NHS is the PCT which covers the whole of the county, and its performance was judged to be adequate in the Audit Commission's 2009 organisational assessment<sup>27</sup>. The County Council was judged to be performing well<sup>28</sup>, while the District Council's was also assessed as adequate<sup>29</sup>. Also of significance is Cambridgeshire Horizons, which is the delivery vehicle for the wider growth area.

## Stoke-on-Trent

- E.31. The City of Stoke was also an early member of the WHO Healthy Cities Programme. It is a unitary authority covering an area broadly coterminous with the local PCT.
- E.32. There is a history of cross-boundary working with Borough of Newcastle Under Lyme, its neighbouring non-unitary district council in Staffordshire's north-western corner. The two

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<sup>27</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=50&area=324&orgId=1082>

<sup>28</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=50&area=324&orgId=1081>

<sup>29</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=50&area=324&orgId=1074>

councils produced a joint core strategy in 2008, which was judged to be sound by the Planning Inspectorate.

- E.33. Stoke has a population of c.240,000 and significant challenges of deprivation to address, arising from the major decline of its traditional industries. People in Stoke generally have much worse health than the England average, and there are health inequalities across largely associated with areas of deprivation. Quality-of-life issues reportedly account for out-migration trends from Stoke into surrounding areas.
- E.34. North Staffordshire Regeneration Partnership brings together the major partners and stakeholders for regeneration projects across public, private and voluntary sectors to drive regeneration in Stoke and Newcastle Under Lyme. RENEW North Staffordshire is the housing market renewal partnership founded in 2004 to address the area's housing demand problems, working in partnership with the Regeneration Partnership.
- E.35. A 2009 organisational assessment by the Audit Commission<sup>30</sup> found Stoke City Council to be performing adequately; but it drew attention to the positive effect that planning for health was having at that time (§101). The organisational assessment of the PCT produced the same result<sup>31</sup>.

## Tower Hamlets

- E.36. Tower Hamlets is a densely populated inner London borough located to the east of the City between the Thames and Olympics site at Stratford in the north. It is one of the most ethnically diverse areas in the country with about half of the population from black and ethnic minority communities; and statistically it is the third most deprived borough in the country. The area of the local PCT is coterminous with the unitary authority's boundaries.
- E.37. After the withdrawal of several LDF documents in 2007 the Core Strategy was submitted in December 2009 and an Examination in Public was held in Spring 2010. The Inspector's report on its soundness is expected later in the year.
- E.38. The Borough Council was judged to be performing well in the Audit Commission's latest organisational assessment in 2009<sup>32</sup>, as too was the local PCT<sup>33</sup>.

<sup>30</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=55&area=412&orgId=1554>

<sup>31</sup> <http://oneplace.audit-commission.gov.uk/infobyorganisation/organisation/Pages/default.aspx?orgId=1539>

<sup>32</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=51&area=416&orgId=1573>

<sup>33</sup> <http://oneplace.audit-commission.gov.uk/infobyarea/region/area/localorganisations/organisation/pages/default.aspx?region=51&area=416&orgId=1574>

## Appendix F: Note of the Workshops

### Workshops on the Health Outcomes in Local Spatial Planning Decisions London and Birmingham: 12/07/2010 and 13/07/2010

#### NOTE OF MAIN POINTS

##### Attendance

See annex for lists of persons attending the workshops

##### Overview

Two workshops were held as part of the research being undertaken for the National Institute for Health and Clinical Excellence (NICE) into spatial planning and health. Health professionals, planners and representatives from other interested organisations were invited to attend the workshops to share their views and experiences and to explore the wider applicability of the emerging research findings.

The workshops began with a brief presentation by the consultant team outlining the purpose of the research, the research programme and emerging findings from the research. The presentation was followed by a plenary discussion in which delegates responded to the presentation and, reflecting on the presentation, highlighted some of the issues they face in practice. Delegates then discussed a series of questions in smaller workshop groups, reporting the outcomes to the wider group.

**Below are listed the key points emerging from discussions at the workshops. It is important to recognise that these reflect the experience and opinions as voiced by participants, and have not been subject to further verification**

##### Initial Plenary Discussion

###### *Principles vs. Practical Implementation*

- In practice, there are major benefits of spatial planners and health professional being “*in the same room*”.
- The new sustainable development agenda has been particularly positive in encouraging spatial planners to think about health.
- While Sustainable Community Strategies usually set out a clear vision for health outcomes, policies to achieve these often appear only implicitly in spatial planning policies.
- However, while it is commonly agreed that having planning policies aimed at health outcomes is good, how these policies will be implemented is often unclear.
- It was noted that, in order to get funding through developer contributions, tackling health issues needs to be written explicitly into planning policy in the Local Development Framework (LDF), and this has not often been the case.

###### *Planning Policy Framework*

- Because health issues are not enshrined in government guidance on planning policy, they tend not to be picked up by planning inspectors when spatial plans are being examined.
- An opportunity for engagement has been missed in Primary Care Trusts (PCTs) not being statutory consultees for planning authorities in LDF preparation.

- In practice, PCTs seem more willing and able to engage with planners around specific issues (e.g. planning applications) than as part of the policy-making process. This may be due to their uncertainty as to what development will happen and its impact on PCT resources.
- In contrast, PCT engagement at the policy-making stage could be beneficial and time-saving in the long term i.e. engaging with policy makers to inform better policies 'upstream' would mean less need for PCTs to engage extensively on individual site applications.
- The implementation of the Community Infrastructure Levy (CIL) or a future "tax" on development could provide greater scope to deliver health initiatives.

### ***Development Control (DC)***

- While PCTs are more comfortable engaging with development control than with forward planning, engagement on big schemes can place significant pressure on PCT resources.
- There can be a disconnection between LDF policies and development control practice - e.g. where DC staff are not focused on implementing a policy framework.
- DC officers are not necessarily thinking about health issues on individual planning applications. If there is consultation, policy planners and/or the PCT are often brought in late, when the main features of a development are already decided.

### ***Transport***

- Transport planners conventionally base their plans on traffic forecast from the status quo and can therefore be unwilling to consider a radical change of direction towards a very different future with a much greater use of walking, cycling and public transport than at present.

### ***Health Planning***

- The national agenda for World-Class Commissioning does actually require a partnering approach, but does not specify this with spatial planning bodies. It also sets out a need for an intelligence function, but this can be "weak and fragmented".
- Funding by PCTs will normally follow policy priorities, not automatically population characteristics in its area. The "choice" agenda has also undermined the functional link to service provision to catchment areas. For these reasons, health planners now find that spatial planning for residential development may be of little value as an input to their planning of services or corporate/financial strategy.
- In London there has been an intention to undertake a strategic identification of locations (sites) for health facilities, but this is not considered to have achieved much success to date.
- Uncertainty about future 'direction of travel' for the NHS - e.g. care closer to home versus poly-clinics - also hinders forward planning.
- Health professionals can set a direction for change, but achieving exact targets is challenging since many health outcomes are difficult to measure, and evidential links to policies/actions is weak. This aspect of health planning can cause frustration for planners.

### ***The Nature of Evidence***

- National planning policy expects a strong evidence base to underpin spatial planning. Local authorities need good evidence which is material to the case in hand to achieve approval for the LDF, decide on applications, seek S106 contributions from developers, or negotiate for other changes to applications to create health outcomes.
- Planning authorities often ask the PCT to demonstrate evidence for the impact a policy initiative or planning proposal will have on health. Impacts on health - and particularly on 'wellbeing' - are difficult to identify and measure. Using resources in gathering evidence

can be unjustifiable in terms of the result, and can actually distract from tackling the issues.

- Developing an evidence base which illustrates the effects of specific initiatives or policies on health can be difficult and takes a long time, and proving cause and effect is challenging. However, some planning authorities have been moving towards more outcome-focused planning, e.g. planners are starting to look at discrepancies in life expectancy between areas.

### ***Sharing Evidence***

- More linkages could be made between Joint Strategic Needs Assessments (JSNAs) and Strategic Housing Market Assessments (SHMAs) - an opportunity to build a common evidence base to be shared by health and planning. Initial guidance on JSNAs did not link them to spatial planning, which may be why opportunities have been missed.
- In one borough, preparing the JSNA was a joint process between the local authority and the PCT. However, there was more input from housing than from planning.
- Some PCTs have found planning departments 'reluctant to share [information] until ready'.

### ***Joint Working***

- Some have found joint working being hindered by a 'timeframe problem' - spatial planning typically deals with 10 to 15 year timescales (e.g. core strategies), while PCTs are working with 3 to 5 year programmes.
- Joint working can also be hindered by 'cultural differences' and lack of knowledge among spatial planners and health professionals of how the others operate.
- Some planning authorities have had difficulty identifying who to contact at the local PCT, and this can be linked to no responsibility for engagement having been designated. Heavy workloads and staff turn-over within PCTs and local authorities can also make it difficult to maintain good communication and effective working relationships.
- Some good practice examples can be identified: a London Borough where the PCT's capital funding schedule is included in the core strategy; PCTs with representatives in the local planning department; staff with a role of ensuring awareness of health among planners.
- Planning policies to support health need to be understood by all as "building blocks" for future interventions which necessitate complementary action by others - i.e. necessary but not sufficient in themselves to provide a solution. Planners therefore need to seek appropriate cooperation in designing policies and then in implementation. Equally, success in this will require support through policies and actions by PCTs and other local authority departments.

### **Workshop discussions**

In small groups, workshop delegates were asked to respond to a series of questions. Responses to the questions are summarised below.

#### ***What characterises an effective working relationship between health and planning?***

- A clear link between spatial planning and health strategies in terms of evidence base and strategic objectives (which could mean closer alignment of the LDF and the Estates Strategy, and/or joint work on the JSNA) - developing mutual objectives would be dependent on early and consistent communication between planners and health professionals.
- A clear understanding of each others' operating structure, timeframe and language. Joint training sessions and seminars for health professionals and planners in some local authorities have been positive in fostering this understanding. Knowledge of each others' work areas has also helped to set expectations of what can realistically be achieved.



- Understanding for each organisation's respective responsibilities and functions, and a method for resolving any conflicts which arise because of these.
- A clear understanding of roles and responsibilities within each organisation, including knowledge of the 'right' person to contact. Joint working is most successful when responsibilities are clearly defined.
- Active mutual support, e.g. health professionals supporting planning policy at inquiry and acting as "expert witnesses" at appeals against planning decisions on health grounds.

***What would "incentivise" a local authority to engage health bodies in decision-making for spatial planning, and vice versa?***

- Funding for joint working and jointly-funded staff.
- Political pressure, either:
  - in the form of top-down guidance through legislation and national policy, or
  - through community pressure to work together. (There is evidence that community engagement around regeneration projects has encouraged health professionals and planners to come together in support of community-generated wellbeing initiatives.)
- Making it prestigious for health professionals and planners to work together.
- Demonstrating the wider benefits of pursuing health outcomes, e.g.:
  - long-term cost savings through reducing the demand on health services;
  - healthy communities which are well provisioned with services and green space will be appealing to buyers and businesses, and can therefore support economic growth.
- Finding opportunities for creating 'win-win' scenarios would favour engagement.

***Which three areas would be the most important as a focus for future guidance by NICE ?***

- Demonstrate the need for legislation or official guidance requiring health professionals and planners to engage in the other's decision making. This could include, for example, a planning policy statement making health a material consideration in planning.
- Provide tools which encourage and support planners in thinking about health, e.g. a health check lists to use in preparing policy, or a health section in planning applications.
- Encourage planners and health professionals to use integrating 'tools' effectively and to gain the appropriate skills - e.g. training and education in each others' work areas.
- Illustrate how planners and health professionals can develop better channels for engagement, including structures and information on who to contact, using cross-over bodies such as LSPs, or identifying leadership roles in facilitating engagement.
- Underline the importance of ensuring the necessary resources to support engagement; and highlight the long-term economic benefits of health initiatives to help make the case for resources.
- Accept the need for dispute resolution when health and planning interests/opinions diverge (e.g. for resolving issues on particular sites) and provide guidance.
- Provide good-practice examples and case studies which set out how specific health interventions have been designed, implemented and monitored.

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DH	Analytical Strategy for the White Paper and Associated Documents <a href="http://www.google.co.uk/url?sa=t&amp;source=web&amp;cd=1&amp;ved=0CB0QFjAA&amp;url=http%3A%2F%2Fwww.dh.gov.uk%2Fprod_consum_dh%2Fgroups%2Fdh_digitalassets%2F%40dh%2F%40en%2F%40ps%2Fdocuments%2Fdigitalasset%2Fdh_117351.pdf&amp;ei=0y5ETMTXAYa6jAe5-JEX&amp;usg=AFQjCNGcdiSdiLaOym9VeoahgRWFOfsvsQ">http://www.google.co.uk/url?sa=t&amp;source=web&amp;cd=1&amp;ved=0CB0QFjAA&amp;url=http%3A%2F%2Fwww.dh.gov.uk%2Fprod_consum_dh%2Fgroups%2Fdh_digitalassets%2F%40dh%2F%40en%2F%40ps%2Fdocuments%2Fdigitalasset%2Fdh_117351.pdf&amp;ei=0y5ETMTXAYa6jAe5-JEX&amp;usg=AFQjCNGcdiSdiLaOym9VeoahgRWFOfsvsQ</a>	2010
DH	Anticipating Future Needs Toolkit <a href="http://www.dhcarenetworks.org.uk/csed/dfAndCapacityPlanning/anticipatingFutureNeeds/">http://www.dhcarenetworks.org.uk/csed/dfAndCapacityPlanning/anticipatingFutureNeeds/</a>	2009
DH	Delivering Health and Well-Being in Partnership: The Crucial Role of the New Local Performance Framework <a href="http://www.communities.gov.uk/documents/localgovernment/pdf/620628.pdf">http://www.communities.gov.uk/documents/localgovernment/pdf/620628.pdf</a>	2007
DH	Enabling Effective Delivery of Health and Wellbeing <a href="http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111693.pdf">http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111693.pdf</a>	2010
DH	Equity and excellence: Liberating the NHS - White Paper <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353</a>	2010
DH	Guidance on JSNAs <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081267.pdf">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081267.pdf</a>	2007
DH	Health Inequalities: Progress and Next Steps <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085312.pdf">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085312.pdf</a>	2008
DH	Independence, Well-Being and Choice <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106478.pdf">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106478.pdf</a>	2005
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DH	JSNA Core Dataset <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099262.pdf">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099262.pdf</a>	2008
DH	New Horizons <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digit">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digit</a>	2009

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DH	Systematically Addressing Health Inequalities <a href="http://collections.europarchive.org/tna/20100509080731/http://dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086570">http://collections.europarchive.org/tna/20100509080731/http://dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086570</a>	2008
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DH / DfT	Active Travel Strategy <a href="http://www.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf">http://www.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf</a>	2010
DH / DWP / HSE	Health, Work and Well-Being - Caring for our Future <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121757.pdf">http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121757.pdf</a>	2005
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Dover District Council	Core Strategy Sustainability Appraisal and Habitats Regulations Assessment Statement <a href="http://www.dover.gov.uk/pdf/SA%20and%20HRA%20Assessment%20Statement.pdf">http://www.dover.gov.uk/pdf/SA%20and%20HRA%20Assessment%20Statement.pdf</a>	2010
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East Cambridgeshire District Council	Sustainable Community Strategy <a href="http://www.eastcambs.gov.uk/local-strategic-partnership/community-strategy">http://www.eastcambs.gov.uk/local-strategic-partnership/community-strategy</a>	2008
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East Kent Local Strategic partnership	EKLSP Sustainable Community Strategy <a href="http://www.eastkentlsp.org.uk/?q=content/strategy">http://www.eastkentlsp.org.uk/?q=content/strategy</a>	2009
East Midlands Regional Assembly	East Midlands Plan <a href="http://www.goem.gov.uk/497296/docs/229865/EMRP">http://www.goem.gov.uk/497296/docs/229865/EMRP</a>	2009
East Midlands Regional Assembly	Regional Public Health Strategy <a href="http://www.emphasisnetwork.org.uk/publications/strategy/emhealthstrategy.pdf">http://www.emphasisnetwork.org.uk/publications/strategy/emhealthstrategy.pdf</a>	2009
East of England Regional Assembly	Integrated Sustainability Assessment Summary, <a href="http://www.eera.gov.uk/GetAsset.aspx?id=fAAzADcANgAzAHwAfABGAGEAbABzAGUAfAB8ADAAfAA1">http://www.eera.gov.uk/GetAsset.aspx?id=fAAzADcANgAzAHwAfABGAGEAbABzAGUAfAB8ADAAfAA1</a>	2010
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NHS Cambridgeshire	Joint Strategic Needs Assessment - Community Views: <a href="http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Joint%20Strategic%20Needs%20Assessment%20for%20Cambridgeshire%20-%20%20Community%20Views.pdf">http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Joint%20Strategic%20Needs%20Assessment%20for%20Cambridgeshire%20-%20%20Community%20Views.pdf</a>	2008
NHS Cambridgeshire	Joint Strategic Needs Assessment Phase 1: <a href="http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Joint%20Strategic%20Needs%20Assessments%20-%20Phase%201.pdf">http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Joint%20Strategic%20Needs%20Assessments%20-%20Phase%201.pdf</a>	2007
NHS Cambridgeshire	Joint Strategic Needs Assessment Phase 2: <a href="http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Joint%20Strategic%20Needs%20Assessment%20for%20Cambridgeshire%20-%20Phase%202%20-%20Nov%202008.pdf">http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Joint%20Strategic%20Needs%20Assessment%20for%20Cambridgeshire%20-%20Phase%202%20-%20Nov%202008.pdf</a>	2008
NHS Cambridgeshire	Joint Strategic Needs Assessment Phase 3: <a href="http://www.cambridgeshire.nhs.uk/downloads/Board%20Meetings/2010/24%20February%202010/4-2%20-%20Joint%20Strategic%20Needs%20Assessment%20Phase%203.pdf">http://www.cambridgeshire.nhs.uk/downloads/Board%20Meetings/2010/24%20February%202010/4-2%20-%20Joint%20Strategic%20Needs%20Assessment%20Phase%203.pdf</a>	2010
NHS Cambridgeshire	Strategic Plan: <a href="http://www.cambridgeshire.nhs.uk/downloads/Annual%20Reports/Annual%20Public%20Health%20Report%202008.pdf">http://www.cambridgeshire.nhs.uk/downloads/Annual%20Reports/Annual%20Public%20Health%20Report%202008.pdf</a>	2008
NHS Leicestershire County and Rutland + Leicestershire County Council	JSNA <a href="http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna1/download/1/JSNA%202009%20Executive%20Summary.pdf">http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna1/download/1/JSNA%202009%20Executive%20Summary.pdf</a>	2009
NHS Leicestershire County and Rutland + Leicestershire County Council	Leicestershire's Staying healthy Strategy 2010-2013 <a href="http://www.lcr.nhs.uk/33LeicestershireTogetherStayingHealthyStrategy-pdf.cmsdoc">http://www.lcr.nhs.uk/33LeicestershireTogetherStayingHealthyStrategy-pdf.cmsdoc</a>	2010
NHS London Healthy Urban Development Unit (HUDU)	Delivering Healthier Communities in London <a href="http://www.healthyurbandevelopment.nhs.uk/documents/integrating_health/HUDU_Delivering_Healthier_Communities.pdf">http://www.healthyurbandevelopment.nhs.uk/documents/integrating_health/HUDU_Delivering_Healthier_Communities.pdf</a>	2007
NHS London HUDU	Health and Urban Planning Toolkit <a href="http://www.healthyurbandevelopment.nhs.uk/documents/engagement_toolkit/HUDU_Health_and_Urban_Planning_Toolkit_Main_Report.pdf">http://www.healthyurbandevelopment.nhs.uk/documents/engagement_toolkit/HUDU_Health_and_Urban_Planning_Toolkit_Main_Report.pdf</a>	2007

NHS London HUDU	Integrating Health into the Core Strategy: A Guide for Primary Care Trusts <a href="http://www.healthyurbandevlopment.nhs.uk/documents/integrating_health/Integrating_Health_into_the_Core_Strategy.pdf">http://www.healthyurbandevlopment.nhs.uk/documents/integrating_health/Integrating_Health_into_the_Core_Strategy.pdf</a>	2009
NHS London HUDU	Planning for Health in London - The ultimate manual for PCTs and Boroughs <a href="http://www.healthyurbandevlopment.nhs.uk/documents/integrating_health/Planning_for_Health_Manual.pdf">http://www.healthyurbandevlopment.nhs.uk/documents/integrating_health/Planning_for_Health_Manual.pdf</a>	2009
NHS London HUDU	Watch Out for Health - Planning Checklist <a href="http://www.healthyurbandevlopment.nhs.uk/documents/integrating_health/HUDU_Watch_Out_For_Health.pdf">http://www.healthyurbandevlopment.nhs.uk/documents/integrating_health/HUDU_Watch_Out_For_Health.pdf</a>	2009
NHS Manchester + Manchester City Council	Joint Strategic Needs Assessment <a href="http://www.manchester.gov.uk/site/scripts/download_info.php?downloadID=2829&amp;fileID=8459">http://www.manchester.gov.uk/site/scripts/download_info.php?downloadID=2829&amp;fileID=8459</a>	2008
NHS Tower Hamlets / LB Tower Hamlets	Improving Health and Well Being in Tower Hamlets 2006-16 <a href="http://www.towerhamlets.nhs.uk/publications/corporate-publications/?entryid4=29504&amp;q=0%c2%acimproving%c2%ac">http://www.towerhamlets.nhs.uk/publications/corporate-publications/?entryid4=29504&amp;q=0%c2%acimproving%c2%ac</a>	2010
NHS Tower Hamlets / LB Tower Hamlets	Joint Strategic Needs Assessment 2008/9	2009
NHS Tower Hamlets / LB Tower Hamlets	Time for Health - the Annual Report of the Joint Director of Public Health <a href="http://www.towerhamlets.nhs.uk/EasySiteWeb/getresource.axd?AssetID=23517&amp;type=full&amp;servicetype=Attachment">http://www.towerhamlets.nhs.uk/EasySiteWeb/getresource.axd?AssetID=23517&amp;type=full&amp;servicetype=Attachment</a>	2009
NICE	Promoting and Creating Built or Natural Environments that Encourage and Support Physical Activity <a href="http://guidance.nice.org.uk/nicemedia/live/11917/38989/38989.pdf">http://guidance.nice.org.uk/nicemedia/live/11917/38989/38989.pdf</a>	2008
North Staffordshire Regeneration Partnership	One Vision - North Staffordshire Regeneration Partnership Business Plan 2009-2012 - Year 2 <a href="http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1832870">http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1832870</a>	2009
North West Regional Assembly	North West of England Plan <a href="http://www.4nw.org.uk/downloads/documents/oct_08/nwra_1224255799_Final_adopted_RSS_300908_Conte.pdf">http://www.4nw.org.uk/downloads/documents/oct_08/nwra_1224255799_Final_adopted_RSS_300908_Conte.pdf</a>	2008
Northumberland National Park Authority	Local Development Framework Core Strategy and Development Policies <a href="http://www.northumberlandnationalpark.org.uk/cs_march_2009.pdf">http://www.northumberlandnationalpark.org.uk/cs_march_2009.pdf</a>	2009
Northumberland National Park Authority	Sustainability Appraisal Report <a href="http://www.northumberlandnationalpark.org.uk/livingin/planning/planningpolicyandguidance/developmentplan/sustainabilityappraisal.htm">http://www.northumberlandnationalpark.org.uk/livingin/planning/planningpolicyandguidance/developmentplan/sustainabilityappraisal.htm</a>	2008
Northumberland Strategic Partnership	Releasing the Strength of our Communities: A Sustainable Community Strategy for Northumberland to 2021 <a href="http://www.nsp.org.uk/downloaddoc.asp?id=1206">http://www.nsp.org.uk/downloaddoc.asp?id=1206</a>	2007
ODPM	Sustainability Appraisal of Regional Spatial Strategies and Local Development Documents	2005

	<a href="http://www.communities.gov.uk/documents/planningandbuilding/pdf/142520.pdf">http://www.communities.gov.uk/documents/planningandbuilding/pdf/142520.pdf</a>	
PAS	Prevention is Still Better than Cure - Planning for Healthy Communities <a href="http://www.pas.gov.uk/pas/aio/92315">http://www.pas.gov.uk/pas/aio/92315</a>	2008
PAS	Signed, Sealed and Delivered - The Benefits of an Adopted Core Strategy <a href="http://www.pas.gov.uk/pas/aio/464251">http://www.pas.gov.uk/pas/aio/464251</a>	2010
Planning Inspectorate	Cambridge East AAP - Inspector's Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906212">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906212</a>	2007
Planning Inspectorate	Cambridge Southern Fringe AAP - Inspector's Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906018">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906018</a>	2007
Planning Inspectorate	East Midlands Regional Plan - Report of the Panel <a href="http://webarchive.nationalarchives.gov.uk/20100528142817/http://www.gos.gov.uk/497296/docs/229865/Panel_Report.pdf">http://webarchive.nationalarchives.gov.uk/20100528142817/http://www.gos.gov.uk/497296/docs/229865/Panel_Report.pdf</a>	2007
Planning Inspectorate	List of Submitted Development Plan Documents (April 2010) <a href="http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/dpd/submitted_dpd_june_10.pdf">http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/dpd/submitted_dpd_june_10.pdf</a>	2010
Planning Inspectorate	Local Development Frameworks: Learning from Experience <a href="http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/ldf_learning_experience_sept2009.pdf">http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/ldf_learning_experience_sept2009.pdf</a>	2009
Planning Inspectorate	Local Development Frameworks: Soundness Guidance <a href="http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/ldf_testing_soundness_feb10.pdf">http://www.planning-inspectorate.gov.uk/pins/appeals/local_dev/ldf_testing_soundness_feb10.pdf</a>	2009
Planning Inspectorate	Northstowe AAP - Inspector's Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905496">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905496</a>	2007
Planning Inspectorate	North-West Cambridge AAP - Inspector's Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=908206">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=908206</a>	2009
Planning Inspectorate	Report on the Examination into the Borough of Poole Core Strategy Development Plan Document <a href="http://www.poole.gov.uk/downloads/assets/Inspectors_Final_Report.pdf">http://www.poole.gov.uk/downloads/assets/Inspectors_Final_Report.pdf</a>	2009
Planning Inspectorate	Report on the Examination into the Mole Valley Core Strategy Development Plan Document <a href="http://www.molevalley.gov.uk/media/pdf/s/q/PDF-_Mole_Valley_CS_Report.pdf">http://www.molevalley.gov.uk/media/pdf/s/q/PDF-_Mole_Valley_CS_Report.pdf</a>	2009
Planning Inspectorate	Report on the Examination into the New Forest District Outside the National Park Core Strategy Development Plan Document <a href="http://www.newforest.gov.uk/media/adobe/p/3/New_Forest_CS_Report_Final_2_.pdf">http://www.newforest.gov.uk/media/adobe/p/3/New_Forest_CS_Report_Final_2_.pdf</a>	2009
Planning Inspectorate	Report on the Examination into the Northumberland National Park Authority Core Strategy Development Plan Document <a href="http://www.northumberlandnationalpark.org.uk/nnpareportpostfactcheck.pdf">http://www.northumberlandnationalpark.org.uk/nnpareportpostfactcheck.pdf</a>	2009
Planning	Report on the Examination into the Southampton Core Strategy Development	2009

Inspectorate	Plan Document <a href="http://www.southampton.gov.uk/s-environment/policy/developmentframework/core-strategy/stage4.aspx#Inspector'sReportanchor">http://www.southampton.gov.uk/s-environment/policy/developmentframework/core-strategy/stage4.aspx#Inspector'sReportanchor</a>	
Planning Inspectorate	Report on the Examination into the Wokingham Borough Core Spatial Strategy Development Plan Document <a href="http://www2.wokingham.gov.uk/index.asp?pgid=81041">http://www2.wokingham.gov.uk/index.asp?pgid=81041</a>	2009
Planning Inspectorate	Report to Hinckley and Bosworth Borough Council <a href="http://www.hinckley-bosworth.gov.uk/ppimageupload/holding/Image88392.PDF">http://www.hinckley-bosworth.gov.uk/ppimageupload/holding/Image88392.PDF</a>	2009
Planning Inspectorate	SE RSS EiP Panel Report <a href="http://www.gov.uk/497648/docs/171301/Examination_in_Public_Panel2.pdf">http://www.gov.uk/497648/docs/171301/Examination_in_Public_Panel2.pdf</a>	2007
Planning Inspectorate	SW RSS Panel Report <a href="http://www.gos.gov.uk/497666/docs/166217/RSSPanelreport">http://www.gos.gov.uk/497666/docs/166217/RSSPanelreport</a>	2007
Poole Partnership	Poole's Sustainable Community Strategy 2006-2012: Shaping Poole's Future <a href="http://www.poolepartnership.info/sustainable-community-strategy/">http://www.poolepartnership.info/sustainable-community-strategy/</a>	2008
RTPI	Delivering Healthy Communities - Good Practice Note 5 <a href="http://www.rtpi.org.uk/download/6443/GPN5_final.pdf">http://www.rtpi.org.uk/download/6443/GPN5_final.pdf</a>	2009
RTPI	Health and Spatial Planning: RTPI Policy Statement <a href="http://www.rtpi.org.uk/download/3505/RTPI-Health-and-Spatial-Planning-Policy-Paper.pdf">http://www.rtpi.org.uk/download/3505/RTPI-Health-and-Spatial-Planning-Policy-Paper.pdf</a>	2009
RTPI	Health and Spatial Planning: Transport and Health <a href="http://www.rtpi.org.uk/download/7242/TransportandHealth.pdf">http://www.rtpi.org.uk/download/7242/TransportandHealth.pdf</a>	2009
Sedgemoor District Council	Draft Sustainable Community Strategy for Sedgemoor 2009-2026 <a href="http://www.sedgemoor.gov.uk/CHttpHandler.ashx?id=4355&amp;p=0">http://www.sedgemoor.gov.uk/CHttpHandler.ashx?id=4355&amp;p=0</a>	2009
Somerset County Council	Somerset a Landscape for the Future: Sustainable Community Strategy for Somerset, 2008-2026 <a href="http://www.somersetstrategicpartnership.org.uk/community/">http://www.somersetstrategicpartnership.org.uk/community/</a>	2009
Somerset County Council	Somerset County Plan, 2010-2013 <a href="http://www.somerset.gov.uk/irj/go/km/docs/CouncilDocuments/SCC/Documents/Resources/Planning%20Performance/County%20Plan_singlepages.pdf">http://www.somerset.gov.uk/irj/go/km/docs/CouncilDocuments/SCC/Documents/Resources/Planning%20Performance/County%20Plan_singlepages.pdf</a>	2009
Somerset Primary Care Trust	Estate Strategy <a href="http://archive.somerset.nhs.uk/publications/Enc%20F%20-%20SPCT%20Estate%20Strategy.pdf">http://archive.somerset.nhs.uk/publications/Enc%20F%20-%20SPCT%20Estate%20Strategy.pdf</a>	2007
Somerset Primary Care Trust	Sustainable Development and Carbon Management Strategy <a href="http://uk.wrs.yahoo.com/_ylt=A03uv8O7iXJMSG4AUwBLBQx.;_ylu=X3oDMTByNGxmazk4BHNIYwNzcgRwb3MDMQRjb2xvA2lyZAR2dGikAw--/SIG=13tld4pcd/EXP=1282661179/**http%3a/www.somerset.nhs.uk/EasysiteWeb/getresource.axd%3fAssetID=739%26type=full%26servicetype=Attachment">http://uk.wrs.yahoo.com/_ylt=A03uv8O7iXJMSG4AUwBLBQx.;_ylu=X3oDMTByNGxmazk4BHNIYwNzcgRwb3MDMQRjb2xvA2lyZAR2dGikAw--/SIG=13tld4pcd/EXP=1282661179/**http%3a/www.somerset.nhs.uk/EasysiteWeb/getresource.axd%3fAssetID=739%26type=full%26servicetype=Attachment</a>	2008
South Cambridgeshire District Council and	Cambridge East AAP <a href="http://www.scamb.gov.uk/admin/documents/retrieve.asp?pk_document=906441">http://www.scamb.gov.uk/admin/documents/retrieve.asp?pk_document=906441</a>	2008

Cambridge City Council		
South Cambridgeshire District Council and Cambridge City Council	Cambridge East AAP - SA Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906445">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906445</a>	2006
South Cambridgeshire District Council	Annual Monitoring Reports <a href="http://www.scambs.gov.uk/Environment/Planning/DistrictPlanning/LocalDevelopmentFramework/Annual_Monitoring_Report.htm">http://www.scambs.gov.uk/Environment/Planning/DistrictPlanning/LocalDevelopmentFramework/Annual_Monitoring_Report.htm</a>	2008, 2009
South Cambridgeshire District Council	Cambridge Southern Fringe AAP - SA Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906446">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906446</a>	2006
South Cambridgeshire District Council	Cambridge Southern Fringe AAP <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906442">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=906442</a>	2008
South Cambridgeshire District Council	Core Strategy - Inspector's Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?doc=1&amp;pk_document=905070">http://www.scambs.gov.uk/admin/documents/retrieve.asp?doc=1&amp;pk_document=905070</a>	2007
South Cambridgeshire District Council	Core Strategy <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905183">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905183</a>	2007
South Cambridgeshire District Council	Development Control Policies - Inspector's Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905457">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905457</a>	2007
South Cambridgeshire District Council	Development Control Policies <a href="http://www.scambs.gov.uk/documents/retrieve.htm?pk_document=905680">http://www.scambs.gov.uk/documents/retrieve.htm?pk_document=905680</a>	2007
South Cambridgeshire District Council	Northstowe AAP <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905692">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905692</a>	2007
South Cambridgeshire District Council	Northstowe AAP - SA Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905693">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=905693</a>	2006
South Cambridgeshire District Council	North-West Cambridge AAP - SA Report: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=907044">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=907044</a>	2008
South Cambridgeshire District Council	North-West Cambridge AAP <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=908354">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=908354</a>	2009



South Cambridgeshire District Council	Statement of Community Involvement <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=908567">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=908567</a>	2010
South Cambridgeshire District Council	Supplementary Planning Documents <a href="http://www.scambs.gov.uk/Environment/Planning/DistrictPlanning/LocalDevelopmentFramework/">http://www.scambs.gov.uk/Environment/Planning/DistrictPlanning/LocalDevelopmentFramework/</a>	2007-2010
South Cambridgeshire District Council	Sustainable Community Strategy: <a href="http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=1976">http://www.scambs.gov.uk/admin/documents/retrieve.asp?pk_document=1976</a>	2008
South Somerset District Council	Core Strategy Issues and Options <a href="http://consult.southsomerset.gov.uk/consult.ti/csissuesandoptions/viewCompoundDoc?docid=73620&amp;sessionid=&amp;voteid=&amp;partId=85300">http://consult.southsomerset.gov.uk/consult.ti/csissuesandoptions/viewCompoundDoc?docid=73620&amp;sessionid=&amp;voteid=&amp;partId=85300</a>	2008
South Somerset District Council	Shaping South Somerset: A Strategy for Sustainable Communities 2008-2026 <a href="http://www.southsomersettogether.org.uk/media/pdf/o/8/Final_Print.pdf">http://www.southsomersettogether.org.uk/media/pdf/o/8/Final_Print.pdf</a>	2008
South West Regional Assembly	SW SIA <a href="http://www.swcouncils.gov.uk/media/SWRA/RSS%20Documents/Final%20Draft/ssamainreport1.pdf">http://www.swcouncils.gov.uk/media/SWRA/RSS%20Documents/Final%20Draft/ssamainreport1.pdf</a>	2006
Southampton City Council	Local Development Framework Core Strategy Development Plan Document <a href="http://www.southampton.gov.uk/s-environment/policy/developmentframework/core-strategy/stage5.aspx">http://www.southampton.gov.uk/s-environment/policy/developmentframework/core-strategy/stage5.aspx</a>	2010
Southampton City Council (Halcrow Group Ltd)	Sustainability Appraisal and Strategic Environmental Assessment: Southampton Local Development Framework Core Strategy. <a href="http://www.southampton.gov.uk/s-environment/policy/developmentframework/core-strategy/integrated-sustainability3.aspx">http://www.southampton.gov.uk/s-environment/policy/developmentframework/core-strategy/integrated-sustainability3.aspx</a>	2008 2009
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Stoke on Trent Health City, Stoke-on-Trent City Council	Declaration for Healthy Cities <a href="http://www.healthycity.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1990710">http://www.healthycity.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1990710</a>	2009
Stoke on Trent Health City, Stoke-on-Trent City Council	Health Development Plan 2005-08 <a href="http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1325240">http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1325240</a>	2005
Stoke on Trent Health City, Stoke-on-Trent City Council	Healthy City Annual Report 2005/06 <a href="http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1433639">http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1433639</a>	2006
Stoke on Trent Health City, Stoke-	Stoke on Trent Healthy City 1998-2013 <a href="http://www.healthycity.stoke.gov.uk/ccm/content/rc/partnerships/healthy-city-">http://www.healthycity.stoke.gov.uk/ccm/content/rc/partnerships/healthy-city-</a>	2006

on-Trent City Council	<a href="http://partnership/Annual-report-05-06/healthy-city-annual-report-05-06.en">partnership/Annual-report-05-06/healthy-city-annual-report-05-06.en</a>	
Stoke on Trent Primary Care Trust	Local Delivery Plan 2008/9 <a href="http://www.stokepct.nhs.uk/pdfs/853.pdf">http://www.stokepct.nhs.uk/pdfs/853.pdf</a>	2008
Stoke on Trent Primary Care Trust	Public Health Annual Report - 2007/08: Reducing inequalities in health outcomes: Progress in Stoke on Trent <a href="http://www.stokepct.nhs.uk/pdfs/860.pdf">http://www.stokepct.nhs.uk/pdfs/860.pdf</a>	2008
Stoke-on-Trent City Council	Health Proofing Masterplans - A Guide (Draft)	2010
Stoke-on-Trent City Council	Housing Strategy - Look Forward - Strategic Review 2009/11 <a href="http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1753343">http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1753343</a>	2009
Stoke-on-Trent City Council	Local Transport Plan 2001-06 <a href="http://www.stoke.gov.uk/ccm/navigation/transport-and-streets-/transport-planning/">http://www.stoke.gov.uk/ccm/navigation/transport-and-streets-/transport-planning/</a>	2000
Stoke-on-Trent City Council	Local Transport Plan 2006 Delivery Report <a href="http://www.stoke.gov.uk/ccm/content/rc/LTP/2006-delivery-report.en">http://www.stoke.gov.uk/ccm/content/rc/LTP/2006-delivery-report.en</a>	2006
Stoke-on-Trent City Council	Strategic Housing Market Assessment 2008 <a href="http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1956550">http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1956550</a>	2008
Stoke-on-Trent City Council	Supporting People Strategy 2005-2010 <a href="http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1501061">http://www.stoke.gov.uk/ccm/cms-service/stream/asset/?asset_id=1501061</a>	2005
Stoke-on-Trent City Council / Newcastle-under-Lyme Borough Council	Joint Core Strategy <a href="http://www.stoke.gov.uk/ccm/navigation/environment/local-development-plans/core-spatial-strategy/">http://www.stoke.gov.uk/ccm/navigation/environment/local-development-plans/core-spatial-strategy/</a>	2009
Stoke-on-Trent City Council and Staffordshire County Council	North Staffordshire Local Transport Plan (2006-11) <a href="http://stoke.gov.uk/ccm/content/rc/LTP/provisional-north-staffordshire-ltp.en">http://stoke.gov.uk/ccm/content/rc/LTP/provisional-north-staffordshire-ltp.en</a>	2006
UNECE	Protocol on Strategic Environmental Assessment to the Convention on Environmental Impact Assessment in a Transboundary Context <a href="http://www.unece.org/env/eia/documents/legaltexts/protocolenglish.pdf">http://www.unece.org/env/eia/documents/legaltexts/protocolenglish.pdf</a>	2003
West Midlands Regional Assembly	Conforming with the region's Spatial Strategy <a href="http://www.wmra.gov.uk/documents/Easy_guide_-_Conforming_with_RSS.pdf">http://www.wmra.gov.uk/documents/Easy_guide_-_Conforming_with_RSS.pdf</a>	2005
West Midlands Regional Assembly	WMRSS Final Sustainability Report, <a href="http://www.wmra.gov.uk/documents/Final%20Sustainability%20Appraisal%20Report%20Non-Technical%20Summary.pdf">http://www.wmra.gov.uk/documents/Final%20Sustainability%20Appraisal%20Report%20Non-Technical%20Summary.pdf</a>	2007
WHO	Social Determinants of Health - the Solid Facts, 2 <sup>nd</sup> Edition <a href="http://www.euro.who.int/_data/assets/pdf_file/0005/98438/e81384.pdf">http://www.euro.who.int/_data/assets/pdf_file/0005/98438/e81384.pdf</a>	2003
WHO Europe	European Healthy Cities Network: Goals and Requirements -Phase V (2009-2013) <a href="http://www.euro.who.int/_data/assets/pdf_file/0009/100989/E92260.pdf">http://www.euro.who.int/_data/assets/pdf_file/0009/100989/E92260.pdf</a>	2009
WHO European	Health Impact Assessment in Strategic Environmental Assessment	2001

Centre for Environment and Health	<a href="http://www.who.int/hia/network/en/HIA_as_part_of_SEA.pdf">http://www.who.int/hia/network/en/HIA_as_part_of_SEA.pdf</a>	
WHO Regional Office for Europe	Declaration: Third Ministerial Conference on Environment and Health <a href="http://www.afro.who.int/era/">http://www.afro.who.int/era/</a>	1999
Wokingham Borough Council	Final Sustainability Appraisal Report: Adopted Wokingham Borough Core Strategy <a href="http://uk.wrs.yahoo.com/_ylt=A03uv8ovjnJMD18BkO5LBQx.:_ylu=X3oDMTByNGxmazk4BHNIYwNzcgRwb3MDMQRjb2xvA2lyZAR2dGlkAw--/SIG=1411oh2m4/EXP=1282662319/**http%3a//www.wokingham.gov.uk/EasySiteWeb/getresource.axd%3fAssetID=129605%26type=full%26servicetype=Attachment">http://uk.wrs.yahoo.com/_ylt=A03uv8ovjnJMD18BkO5LBQx.:_ylu=X3oDMTByNGxmazk4BHNIYwNzcgRwb3MDMQRjb2xvA2lyZAR2dGlkAw--/SIG=1411oh2m4/EXP=1282662319/**http%3a//www.wokingham.gov.uk/EasySiteWeb/getresource.axd%3fAssetID=129605%26type=full%26servicetype=Attachment</a>	2010
Wokingham Borough Council	Wokingham Borough Core Strategy Development Plan Document <a href="http://http://www.wokingham.gov.uk/corestrategy">http://http://www.wokingham.gov.uk/corestrategy</a>	2010
Wokingham Borough Strategic Partnership	Innovating Wokingham: A Sustainable Community Strategy for Wokingham 2010 - 2020 <a href="http://www.wokinghamboroughstrategicpartnership.gov.uk/community-strategy">http://www.wokinghamboroughstrategicpartnership.gov.uk/community-strategy</a>	2010

## Appendix H: Glossary

AAP	Area Action Plan (see §2.20)	
AGMA	Association of Greater Manchester Authorities	
AMR	Annual Monitoring Report	
CABE	Commission for Architecture and the Built Environment	
CIL	Community Infrastructure Levy (see §2.29)	
CLG	Department of Communities and Local Government	
DH	Department of Health	
DPD	Development Plan Document (see §2.17)	
EIA	Environmental Impact Assessment (see §???)	
EiP	Examination in Public (of a RSS)	
GLA	Greater London Assembly	
GM	Greater Manchester	
GMITA	Greater Manchester Integrated Transport Authority	
GO	Government Regional Office	
GP	general medical practitioner	
HIA	Health Impact Assessment (see §3.13)	
HUDU	Healthy Urban Development Unit (of London's PCTs)	

IDeA	Improvement and Development Agency	
IMD	Index of Multiple Deprivation	
JHU	Joint Health Unit	
JSNA	Joint Strategic needs Assessment (see §2.58)	
LAA	Local Area Agreement (see §2.66)	
LDD	Local Development Document (see §2.17)	
LDF	Local Development Framework (see §2.14)	
LSP	Local Strategic Partnership (see §2.16)	
LTP	Local Transport Plan (includes LTP1, LTP2, LTP3)	
NHS	National Health Service	
NICE	National Institute for Health and Clinical Excellence	
ONS	Office for National Statistics	
PCT	Primary Care Trust	
PPS	Planning Policy Statement	
RSS	Regional Spatial Strategy	
RTPI	Royal Town Planning Institute	
s106	Section 106 (of the Town and Country Planning Act, 1990)	
SA	Sustainability Appraisal (see §3.13)	
SCS	Sustainable Community Strategy (see §2.16)	

SPD	Supplementary Planning Document (see §2.17)	
SPG	Supplementary Planning Guidance (see SPD)	
WHO	World Health Organisation	